EDS Systems Unit

Systems Documentation - RAMS II

LIBRARY REFERENCE NUMBER: SU10001 REVISION DATE: March 2004 VERSION 2.0

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INDIANA HEALTH COVERAGE PROGRAMS

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Revision History

Document Version Number	Revision Date	Revision Page Number(s)	Reason for Revisions	Revisions Completed By
Version 1.0	2000 Update	All	New Format and Report Layouts	Mark Wheatley
Version 2.0	March 2004	All	HIPAA updates, repaginate to print double-sided, converted fonts and margins to style guide standards, changed name throughout to *Systems Documentation* from *Users Guide*. Added CPT/CDT disclaimer.	HIPAA Publications

Table of Contents

Section 1: Introduction

Overview

The Indiana*AIM* Surveillance and Utilization Review function (SUR) is a flexible management tool that can help the SUR Analyst identify patterns of inappropriate care and services. From Medicaid provider and recipient actual claim data, averages, trends and comparisons are computer generated to reveal deviations from the established normal practice patterns of their peers. The deviations are then assigned numeric weight values and ranked by their total weight assigned. From these rankings, the majority of review cases originate. Detailed claim service reports displaying, providers/recipients of service, procedure codes, diagnosis codes, dates and payments, may also be generated to more specifically analyze each case.

The Retrospective Analysis of Medical ServicesRAMS II) function used by the State of Indiana is a federally approved SUR System. State Medicaid Programs are encouraged by the Health Care Financing Administration (HCFA) to employ such a monitoring/reporting function and must do so to receive increased federal matching funds for their programs. The SUR function must conform to HCFA established functional requirements and objectives in order to be federally certified as an integral component of the total Medicaid Management Information System (MMIS). The SUR function is one of six required MMIS functional components; others are Recipient, Provider, Claims, Reference, and Management/Administrative Reporting. Upon certification, and periodically thereafter, the State Medicaid Administration processes are reviewed by the HCFA to ensure continued compliance with program requirements. This review process is called System Performance Review (SPR). If the results of an SPR are unsatisfactory, federal matching funds may be withheld and/or associated penalties may be assessed.

HCFA's long range objectives of MMIS are to realize efficient and effective administration of the Title XIX (Medicaid) Program and to reduce program costs. HCFA objectives specific to the development of the SUR function are: 1) Provide information which will reveal and facilitate detection of potential defects in the level of care or quality of service provided under the Medicaid Program, 2) Reveal and investigate potential misutilization and promote corrective actions, 3) Help in establishing specific data edits and medical policy to be used in the claims processing operation that have proved to be useful in identifying unacceptable claims, and 4) accomplish these objectives with a minimum amount of clerical effort and a maximum degree of flexibility.

The SUR function is one of the primary tools of the SUR unit. The reports alone will not stop misutilization, but can be used to detect and substantiate fraud and abuse, as well as provide information needed to initiate corrective actions and educate providers and recipients, thus reducing program costs.

Section 2: Subsystem Overview

Building of Information

The SUR reports are based on the detail information from adjudicated (paid or denied) claims. The detail information is arranged into categories of similar participants. Individual categories of "like" recipients or providers are called peer groups. Peer group averages and utilization trends are computed on selected statistical items which are designed to reflect an overall picture of medical practice and diagnosis treatment. The medical activity for individual providers and recipients is then compared to criteria the peer group has established as "normal" activity for each parameter. Participants who have deviated above or below a pre-determined limit or margin of the peer group average are "flagged" for the exception. Each statistical item an individual participant has excepted on will be assigned a weight. Providers and recipients within each peer group are then ranked according to their total exception weight. Participants having the highest weight will be ranked first indicating to the reviewer that misutilization of the program is potentially greater among these users. This information building is illustrated by the pyramid diagram below:

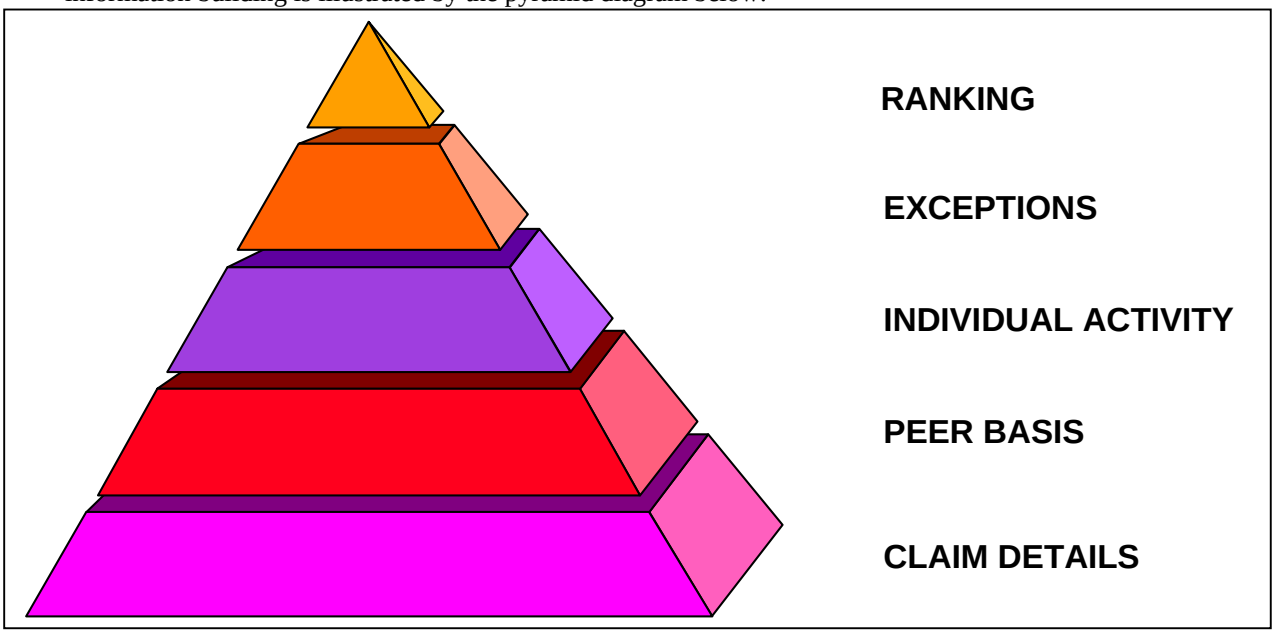


Figure 1 – Information Building Pyramid

The SUR subsystem performs the following high-level functions:

- Update the SURS Control Files
- Extract paid claims data
- Process Quarterly Reports
- Interface with other subsystems in the MMIS to receive or provide needed data

Each of these automated functions is further discussed below, along with a description of the relevant inputs and outputs. The manual functions related to the SUR subsystem are an integral part of operations and are described in this manual.

Updating SURS Control Files

Each quarter the SUR contractor and the IFSSA define the upcoming reporting cycle. This information includes, but is not limited to the following:

- Reports to produce
- Dates of the reporting period
- Reporting minimums
- Changes to peer grouping schemes for providers and recipients
- Changes to cross-referencing schemes for diagnosis and procedure codes
- Date ranges for selected history detail reporting
- Summary profile line item control parameters
- Selected providers and recipients

After the changes to the control files are properly updated, edit reports are printed showing current control file data. Subsequent to the review of these reports, the quarterly reporting process is initiated.

Inputs

Current SURS Control Files

Outputs

New SURS Control Files

Extract Claims History

The Extract Claims History process is performed upon quarterly report cycle initiation. SUR uses the claims history data store to extract the previous fifteen (15) months of paid claims history into the SURS extract data store. After the extract process is complete, the SUR extract is used as input to the SUR quarterly cycle. The SUR Master File contains the most recent fifteen (15) months of paid claims data.

Inputs

- SURS Control Files
- Claim History Extract Data
- Recipient Data
- Provider Data
- Reference Data

Outputs

- SURS Extract
- Updated SURS History

Process Quarterly Reports

The quarterly reporting process begins after the SURS history files are updated. The process produces reports organized into the seven (7) categories that follow:

- Detail provider reports - the provider history details are displayed in these reports. Research with these reports may uncover specific patterns of abuse which are not detectable in other reports.
- Diagnosis and procedure distribution reports - these reports provide volume analysis and ranking of procedure and diagnosis codes.
- Selected claims reports - available to support investigation of potential misutilization. These reports reflect an in-depth accounting of each service provided or received for a specified time frame.

- Provider and recipient summary profile analysis reports - present a Medical Assistance activity summary for each participant. These activity summaries are comprised of statistical report items selected by the user to reveal common types of misutilization. Individual utilization is compared to the peer group averages and the exceptions above or below the allowed variances are flagged and exception weight is assigned.

- Treatment analysis reports - perform a comprehensive analysis of diagnosis treatment patterns. Treatment analysis reports provide a detailed analysis of the procedure codes used for each diagnosis category for which a provider has rendered treatment.

- DRG reports - measure length of stay / quality and cost effectiveness of inpatient care under the DRG reimbursement methodology.

- Long term care reports - display information on services rendered to the recipients who reside at a long term care facility.

Inputs

- SURS Control Files

- Recipient Data

- Provider Data

- Reference Data

- SURS History Files

Outputs

- SURS Quarterly Reports

Interface with Other Subsystems in the MMIS to Receive or Provide Needed Data

The SUR subsystem receives data from the following MMIS subsystems:

- Reference - Procedure, Diagnosis, DRG and NDC information

- Claims - Claims data

- Provider - Provider related data

- Recipient - Recipient related data

The SUR subsystem provides data to the following MMIS subsystems:

- None

Peer Grouping

Peer groups are established to ensure that analysis and reporting reflect medical treatment characteristics in a meaningful perspective. Members are usually grouped based on their category of assistance. If desired, the Indiana*AIM* RAMS II function allows recipient peer groups to be further defined based on one or a combination of the following data elements:

Age Living Arrangement/LTC Indicator

Sex Geographic Region

Race Agency Origin/Special Programs Indicator

By grouping recipients in this manner, an individual of Old Age Assistance who resides in a nursing home and receives numerous prescription drugs for arthritis and heart disease is not compared to a child on the AFDC Program who sees a physician twice a year for minor ailments.

Categories of Service split providers into the principal kinds of services rendered under the Title XIX Program. These categories are defined based on provider type, provider specialty, and in some cases, claim type.

Provider peer groups within each Category of Service are determined by a combination of several factors as defined by the user. Providers are usually grouped based on specialty, and geographic region, for institutional providers; however the Indiana*AIM* RAMS II functional capabilities also allow peer grouping based Type of Practice/Organization and Facility Type. By establishing these categories of service and peer groups, providers are segregated by their expected volume of practice and anticipated treatment patterns. Therefore, large dollar/patient volume hospitals whose diagnosis treatment would be represented by accommodation/ancillary and DRG codes are not compared to physicians whose practice is comprised mainly of office visits and miscellaneous lab work.

The categories of service established for Indiana*AIM* SURS reporting were designed to parallel the Management and Administrative Reporting (MARS) categories of service, as much as possible, for consistency throughout the MMIS. Categories of service utilized for the Indiana SURS reporting are:

Code	Description	Code	Description
01	Inpatient	11	Lab / X-Ray / Specialty Clinic
03	Outpatient	13	Transportation / Special Services
04	PCCM	14	Long Term Care
06	Physician (MD/DO)	20	Therapy Services / Nurse
07	Pharmacy / Suppliers	22	Mental Health
08	Suppliers	23	Dental / Optometric
33	Waiver Programs		

Diagnosis and Procedure Grouping

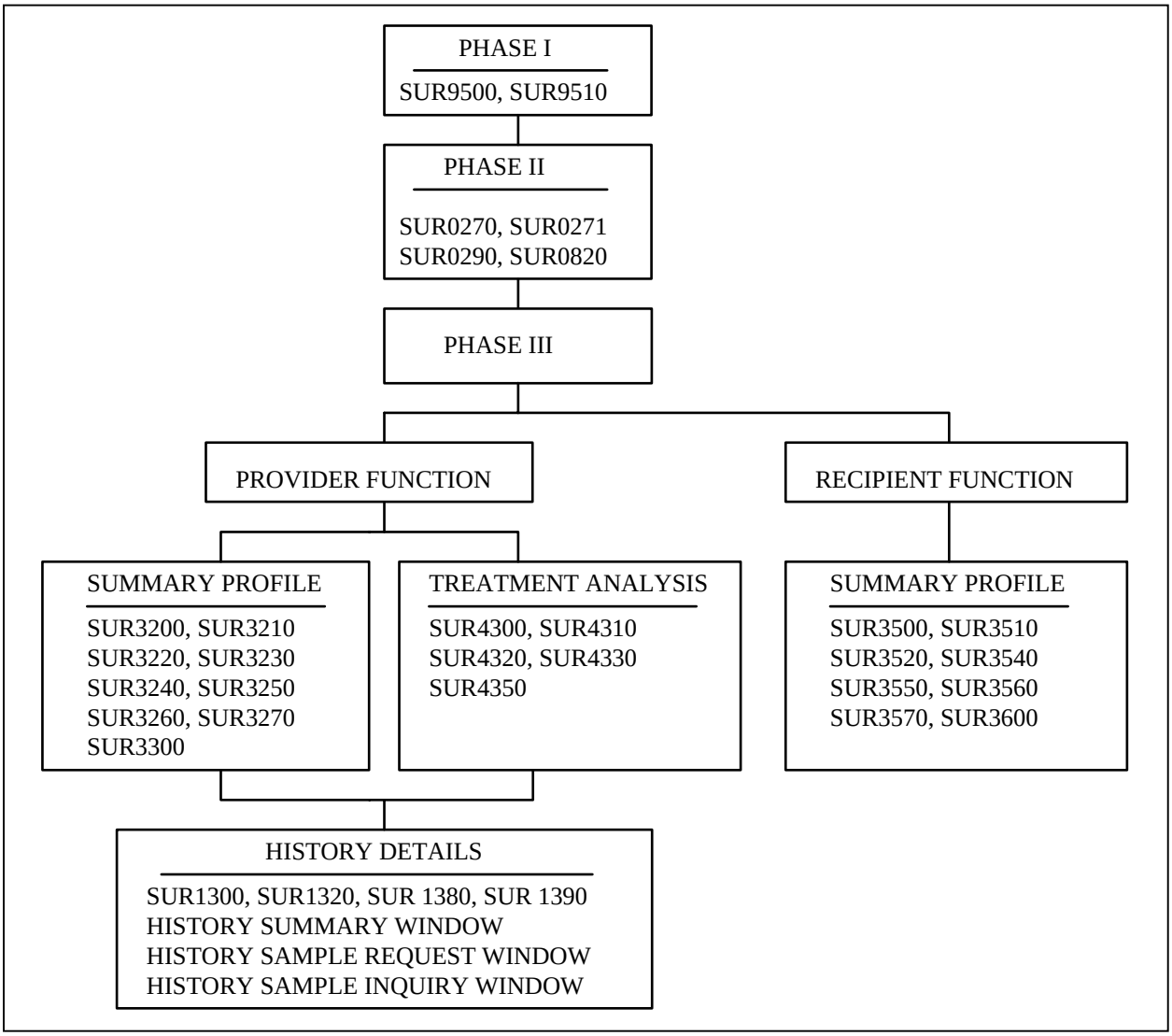
Related diagnosis and procedure codes are also categorized to promote the ease and effectiveness of reporting. For example, assume there are ten procedure codes for varying levels of service of office visits. Since these codes represent similar services, they could be grouped under one cross-reference code, e.g. 9000, and all office visits would be considered as a visit when establishing treatment models. In the same manner there are several diagnosis codes for each of the common maladies. Appendicitis, for instance, may have six diagnosis codes but the treatment would be the same regardless of which specific code the provider chose to submit on the claim.

By grouping diagnoses and procedures with similar characteristics, an adequate data base is established and the reports are produced at a manageable and workable level.

Section 3: System Flow – RAMS II Reports

Overview

The system flow of the RAMS II reports can be visualized in the diagram below. Phase I is a volume analysis of procedure and diagnosis codes. Phase II establishes the treatment models for peer groups. Phase III is the exception ranking of individual providers and recipients with summary profile, treatment exception, and history detail reporting for use in documenting specific abuses.



Section 4: Phase I Reports

Overview

The three reports generated in Phase I are the most generalized accumulation of data from the paid claims file and provide a volume analysis and ranking of procedure, diagnosis and DRG codes. For each code reported, the number of services/occurrences, dollars billed, allowed and paid are shown. The special on-request reports of Phase I can be generated quarterly and annually, in any of the optional sequences to support special management or utilization review studies. The user defined report parameters are maintained on the Options Control File. A separate Cross reference Control File can be created for the user defined cross reference values.

Distribution

- Procedure Code Distribution and Statistical Summary
- Diagnosis Code Distribution and Statistical Summary
- DRG Distribution and Statistical Summary

Report Definition: SUR-9500-A Procedure Code Distribution and Statistical Analysis

Part I Report Definition Information

Functional Area:	SURS
Report Number:	SUR-9500-A
Job Name:	SRGJQ950
Report Title:	Procedure Code Distribution and Statistical Analysis

Description of Information

The Procedure Code Distribution and Statistical Analysis Report provides a volume analysis of code usage within a defined population (peer group or statewide).

User options appear in bold print

Table 4.1 – User Options

Options	Description
Reporting Period	The time frame reflected by the data on the report.
Locality	Can be set to "**all**" for a statewide total, cross-reference values, or original values.
Specialty	Can be set to "all" for statewide total, **cross-reference values**, or original values.
Type	Can be set to "all" for statewide total, **cross-reference values**, or original values.
Diagnosis	Can be set to "**all**" for statewide total, cross-reference values, or original values.
Procedure	Cross-reference values or **original** values can be used.
COS	Can be broken out by category of service, or reported for all categories combined. **both**
Place of service	Can be broken out by place of service, or reported for **all** places of service.

Purpose of Report

The Procedure Code Distribution and Statistical Analysis Report can be used to establish review priorities for Summary Profile line items and procedure cross-reference values for the Treatment Analysis Subsystem. Annual and quarterly reviews can be performed using this report to monitor the changing treatment patterns of the medical community within the state or within a provider peer group.

Sort Sequence

Peer group or statewide, then any of the following sequence criteria:

* An asterisk identifies sorts currently produced.

- Procedure *
- Number of services/occurrences *
- Amount allowed
- Amount billed

- Amount paid *
- Average services

Distribution

Distribution	Media	Copies	Frequency
IFSSA	Microfiche		Quarterly and Annually
EDS	Microfiche		Quarterly and Annually

Report Definition – Procedure Code Distribution and Statistical Analysis

Part II Report Definition Information

Functional Area: SURS

Report Number: SUR-9500-A

Detailed Field Definitions

Table 4.2 – Header Information

Field	Description
Period	The time frame reflected on the report.
COS	Category of service, if requested.
POS	Place of service, if requested.
LOC Code	Locality code and description.
TYP	Provider type code and description.
SPC	Specialty code and description.
Diagnosis	Diagnosis code and description.
Report Sequence	**Procedure**
	Number of services
	Amount allowed
	Amount billed
	Amount paid
	Average Amount

Table 4.3 – Detail Information

Field	Description
Proc Code	The procedure code.
Description	Narrative description of the procedure code.
Mean Al/Svc	Total amount allowed divided by the number of services.
Std Dev	Variance of individual procedure code amount above or below the mean.
M+1SD	Mean plus one standard deviation.
M+2SD	Mean plus two standard deviations.
Services/Number and Pcnt	Number of services for each procedure code and the number of services as a percent of total services.
Billed/Amount and Pcnt	Total dollar amount billed for each procedure code and the percent of total billed.
Allowed/Amount and Pcnt	Total dollar amount allowed for each procedure code and the percent of total allowed.
Paid/Amount and Pcnt	Total dollar amount paid for each procedure and the percent of total paid.
Subtotal	Subtotal information is displayed for each of the optional sequence criteria selected for reporting in the Options Control File.
Services/Number and Pcnt	Total number of services for all procedure codes and the number of services as a percent of total services for the sort sequence.
Billed/Amount and Pcnt	Total dollar amount billed for all procedure codes and the percent of total billed for the sort sequence.
Allowed/Amount and Pcnt	Total dollar amount allowed for all procedure codes and the percent of total allowed for the sort sequence.
Paid/Amount and Pcnt	Total dollar amount paid for all procedures and the percent of total paid for the sort sequence.

Table 4.3 – Grand Totals Information

Field	Description
Number Services	Total number of services for the entire report, including all sort sequences.
Billed Amount	Total dollar amount billed for the entire report, including all sort sequences.
Allowed Amount	Total dollar amount allowed for the entire report, including all sort sequences.
Paid Amount	Total dollar amount paid for the entire report, including all sort sequences.

Report Example: Procedure Code Distribution and Statistical Analysis

```
  REPORT:   SUR-9500- A                                        INDIANAAIM                                PAGE 99,999
 PROCESS:   SRGJQ950                                                                                    RUN DATE: MM/DD/CCYY
LOCATION:   SRGP9502                  PROCEDURE CODE DISTRIBUTION AND STATISTICAL ANALYSIS REPORT

PROGRAM: MEDICAID                                                                                PERIOD: MM/CCYY THRU MM/CCYY

COS  99        LOC    XXXX                    TYP    XXXX                              SPC    XXXX

POS  99  XXXXXXXXXXXXXXXX  DIAGNOSIS XXXXXXX  XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX                   REPORT SEQUENCE -:
XXXXXXXXXXXXXXXXXXX

TS/PROC CODE ----------DESCRIPTION----------------------------

         -MEAN-  -STD DEV-   -M+1SD-   -M+2SD-   --SERVICES--          ---BILLED---          ---ALLOWED----           -----PAID----
         PD/SVC                                   NUMBER  PCNT          AMOUNT  PCNT          AMOUNT    PCNT           AMOUNT   PCNT

XXXXXXXXXXXXX    XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX
          99.99    999.99     999.99    999.99   99,999  99.99     999,999.99  99.99     999,999.99   99.99       999,999.99  99.99

**************************************************************************************************************************************

SUBTOTAL      DIAGNOSIS  XXXXXX   XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX

              NUM TS/PROC CODES  999,999   999,999,999  999.99 999,999,999.99 999.99  999,999,999.99 999.99   999,999,999.99 999.99

SUBTOTAL      LOC-ALL  TYP-ALL   SPC-ALL

              NUM DIAG CODES     999,999   999,999,999  999.99 999,999,999.99 999.99  999,999,999.99 999.99   999,999,999.99 999.99

SUBTOTAL      COS  99            999,999   999,999,999         999,999,999.99         999,999,999.99          999,999,999.99

********************************************************** GRAND TOTALS ***********************************************************

                                        999,999,999      99,999,999,999.99      99,999,999,999.99       99,999,999,999.99
```

Report Definition: SUR-9510-A Diagnosis Code Distribution and Statistical Analysis

Part I Report Definition Information

Functional Area:	SURS
Report Number:	SUR-9510-A
Job Name:	SRGJQ950
Report Title:	Diagnosis Code Distribution and Statistical Analysis

Description of Information

The Diagnosis Code Distribution and Statistical Analysis Report provides a volume analysis of code usage within a defined population (peer group or statewide).

Table 4.4 – User Options

User options appear in bold.

Option	Description
Reporting Period	Any time frame within 36 month of the available data base
Locality	Can be set to "**all**" for a statewide total, cross-reference values, or original values
Specialty	Can be set to "all" for statewide total, **cross-reference values**, or original values
Type	Can be set to "all" for statewide total, **cross-reference values**, or original values
Diagnosis	Cross-reference values or **original** values can be used

Purpose of Report:

The diagnosis ranking provided by the Diagnosis Code Distribution and Statistical Analysis Report can be used as the prime target for treatment analysis. Disease occurrences within the peer groups, or statewide, can be monitored and analyzed for effective utilization review and program management.

Sort Sequence

Peer group or statewide, then any of the following sequence criteria:

* An asterisk identifies sorts currently produced.

- Diagnosis *
- Number of services/occurrences *
- Amount allowed
- Amount billed
- Amount paid *
- Average services

Distribution

Distribution	Media	Copies	Frequency
IFSSA	Microfiche		***Quarterly and Annually***
EDS	Microfiche		Quarterly and Annually

Report Definition: SUR-9510-A Diagnosis Code Distribution and Statistical Analysis

Part II Report Definition Information

Functional Area: SURS

Report Number: SUR-9510-A

Detailed Field Definitions

Table 4.5 – Header Information

Field	Description
Period	The time frame reflected on the report.
COS	Category of service, if requested.
POS	Place of service, if requested.
Locality Code	Locality code and description.
TYP	Provider type code and description.
SPC	Specialty code and description.

Table 4.5 – Header Information

Field	Description
Report Sequence	**Diagnosis**
	Number of services
	Amount allowed
	Amount billed
	Amount paid
	Average Amount

Table 4.6 – Detail Information

Field	Description
Diagnosis	The diagnosis code.
Description	Narrative description of the diagnosis code.
Num Proc	The number of different procedure codes reported for the diagnosis.
Services/Number and Pcnt	Number of services for each diagnosis code and the number of services as a percent of total services.
Billed/Amount and Pcnt	Total dollar amount billed for each diagnosis code and the percent of total billed.
Allowed/Amount and Pcnt	Total dollar amount allowed for each diagnosis code and the percent of total allowed.
Paid/Amount and Pcnt	Total dollar amount paid for each diagnosis and the percent of total paid.
Mean Al/Svc	The average dollars allowed per service for each diagnosis.

Table 4.7 – Subtotal

Field	Description
Num Diag Codes	Total number of diagnosis codes for the sort sequence.
Services/Number and Pcnt	Total number of services for all diagnosis codes and the number of services as a percent of total services for the sort sequence.
Billed/Amount and Pcnt	Total dollar amount billed for all diagnosis codes and the percent of total billed for the sort sequence.
Allowed/Amount and Pcnt	Total dollar amount allowed for all diagnosis codes and the percent of total allowed for the sort sequence.
Paid/Amount and Pcnt	Total dollar amount paid for all diagnoses and the percent of total paid for the sort sequence.

Table 4.8 – Grand Totals Information

Field	Description
Number Services	Total number of services for the entire report, including all sort sequences.
Number of Devices Denied	Total number of services denied for the entire report, including all sort sequences
Billed	Total dollar amount billed for the entire report, including all sort sequences.
Allowed	Total dollar amount allowed for the entire report, including all sort sequences.
Paid	Total dollar amount paid for the entire report, including all sort sequences.
Denied	Total dollar amount denied for the entire report, including all sort sequences

Report Example: Diagnosis Code Distribution and Statistical Analysis

```
  REPORT:   SUR-9510- A                                   INDIANAAIM                                          PAGE 99,999
 PROCESS:   SRGJQ950                                                                                         RUN DATE: MM/DD/CCYY
LOCATION:   SRGP9512                  PROCEDURE CODE DISTRIBUTION AND STATISTICAL ANALYSIS REPORT

PROGRAM: MEDICAID                                                                                PERIOD: MM/CCYY THRU MM/CCYY

COS  99        LOCALITY   XXXX                   TYP    XXXX                          SPC    XXXX

                                               REPORT SEQUENCE -   XXXXXXXXXXXXXX

DIAGNOSIS   ----------DESCRIPTION----------------------------

                              --NUM--       --SERVICES--         ---BILLED---          ---ALLOWED----           -----PAID----  -MEAN-
                                PROC         NUMBER  PCNT         AMOUNT  PCNT          AMOUNT    PCNT           AMOUNT   PCNT  AL/SVC

  XXXXXX     XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX
                         99999        99,999  99.99       999,999.99  99.99     999,999.99   99.99       999,999.99  99.99   99.99

 XXXXXX     XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX
                         99999        99,999  99.99       999,999.99  99.99     999,999.99   99.99       999,999.99  99.99   99.99

 XXXXXX     XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX
                         99999        99,999  99.99       999,999.99  99.99     999,999.99   99.99       999,999.99  99.99   99.99
XXXXXX     XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX
                         99999        99,999  99.99       999,999.99  99.99     999,999.99   99.99       999,999.99  99.99   99.99

 ************************************************************************************************************************************

SUBTOTAL      LOC-ALL  TYP-ALL   SPC-ALL

        NUM. DIAG CODES 999,999   999,999,999  999.99 999,999,999.99 999.99  999,999,999.99 999.99   999,999,999.99 999.99

SUBTOTAL      COS  99             999,999,999         999,999,999.99         999,999,999.99          999,999,999.99

********************************************************* GRAND TOTALS *********************************************************

                                 999,999,999      99,999,999,999.99      99,999,999,999.99       99,999,999,999.99
 SUBTOTAL                        999,999,999       99,999,999,999.99     99,999,999,999.99       99,999,999,999.99
```

Report Definition: SUR-9530-A DRG Distribution and Statistical Analysis

Part I Report Definition Information

Functional Area:	SURS
Report Number:	SUR-9530-A
Job Name:	SRGJQ950
Report Title:	DRG Distribution and Statistical Analysis

Description of Information

The DRG Distribution and Statistical Analysis Report provides a volume analysis of DRG code occurrences within a defined population (peer group or statewide).

Table 4.9 – User Options

User options appear in bold.

Options	Description
Reporting Period	Any time frame within 36 months of the available data base

Purpose of Report:

The DRG ranking provided by the DRG Distribution and Statistical Analysis Report can be used to monitor and analyze inpatient hospital occurrences as well as for program management.

Sort Sequence:

* An asterisk identifies sorts currently produced.

Peer group or statewide, then any of the following sequence criteria:

- DRG *
- Number of services/occurrences *

- Amount billed
- Amount paid *

Distribution

Distribution	Media	Copies	Frequency
IFSSA	Laser Print		Quarterly and Annually
EDS	Laser Print		Quarterly and Annually

DRG Distribution and Statistical Analysis

Part II Report Definition Information

Functional Area: SURS

Report Number: SUR-9530-A

Detailed Field Definitions

Table 4.10 – Header Information

Field	Description
Period	The time frame reflected on the report.
Peer Group	Provider peer group code and description.
Report Sequence	**DRG**
	Number of occurrences
	Amount billed
	Amount paid

Table 4.11 – Detail Information

Field	Description
DRG Code	The diagnosis related grouping code.
Description	Narrative description of DRG.
Occurs Number and Pcnt	Total number of occurrences for this DRG and percent of all DRGs for this peer group or statewide.
Occurs Denied Number and Pcnt	Number of occurrences for this DRG which had paid amount = 0, and percent of all DRGs for this peer group or statewide.
Billed Amount and Pcnt	Total amount billed for this DRG and percent of total dollars billed for this DRG for this peer group or statewide.
Allowed Amount and Pcnt	Total amount allowed for this DRG and percent of total dollars allowed for this DRG for this peer group or statewide.
Paid Amount and Pcnt	Total amount paid for this DRG and percent of total dollars paid for this DRG for this peer group or statewide.
Denied Amount and Pcnt	Total amount billed that was denied (paid amount = 0) for this DRG and percent of all DRGs for this peer group or statewide.
Mean Pd/Svc	Average amount paid for this service calculated as follows:
	Mean Pd/Svc = Amount Paid
	(Occurrences - Occurrences denied)

Report Example: DRG Distribution and Statistical Analysis

```
  REPORT:  SUR-9530- Q                                    INDIANAAIM                                    PAGE NUM:     1
 PROCESS:  SRGJA950                                                                                    RUN DATE:  09/28/2000
LOCATION:  SRGP9532                        DRG CODE DISTRIBUTION AND STATISTICAL ANALYSIS

 PEER GROUP: COS - 01 LOC - ALL  TYPE - ALL  SPEC - 010     REPORT SEQUENCE:  DRG CODE              PERIOD: 10/1999 THRU 09/2000
```

DRG	DESCRIPTION	-OCCURENCES- NUMBER	PCNT	---BILLED---- AMOUNT	PCNT	---ALLOWED--- AMOUNT	PCNT	-----PAID---- AMOUNT	PCNT	-MEAN- AL/OCC
0001	CRANIOTOMY AGE >17 EXCEPT FOR TRAUMA	87	0.11	139,580.72	0.25	83,871.74	0.29	83,871.74	0.29	964.04
0002	CRANIOTOMY FOR TRAUMA AGE >17	11	0.01	32,529.69	0.06	17,368.87	0.06	17,368.87	0.06	1,578.99
0004	SPINAL PROCEDURES	30	0.04	28,309.04	0.05	19,927.56	0.07	19,927.56	0.07	664.25
0005	EXTRACRANIAL VASCULAR PROCEDURES	46	0.06	52,859.90	0.10	4,749.19	0.02	4,749.19	0.02	103.24
0006	CARPAL TUNNEL RELEASE	1	0.00	245.00	0.00	0.00	******	0.00	******	0.00
0007	PERIPH,CRAN NERV/OTH NERV SYS PROC W CC	26	0.03	24,648.43	0.04	19,787.33	0.07	19,787.33	0.07	761.05

```
**********************************************************************************************************************
*******
```

SUBTOTAL PEER GROUP - ALL	NUM. DRG CODES 9								
	119	0.14	192,995.45	0.26	159,463.90	0.37	159,463.90	0.37	

```
********************************************************** GRAND TOTALS
**********************************************************
```

83,386	75,320,411.60	43,306,923.93	42,566,691.24

Section 5: Phase II Reports

Overview

The reports generated in Phase II establish treatment models for each peer group, which are compared to the practice of individual providers in Phase III. A treatment model is the pattern of medical care that can be expected when a specific diagnosis has occurred. Three options defined by the user apply to the Phase II and Phase III reports of the Treatment Analysis Subsystem.

Categories of Service

The user has the option to select which categories should be processed through Treatment Analysis. The physician category of service, comprising the majority of basic medical care, produces the most useful treatment data.

Age/Sex Breakouts

The user has the option of analyzing diagnosis treatment within five user defined age groupings and/or by sex. When this option is applied to Phase II reports it will also be used to produce the Provider Treatment Exception Reports in Phase III.

Total Practice

Selection of this option will instruct the system to analyze procedure use regardless of diagnosis. The effect is the same as if all diagnoses were cross-referenced to one value, resulting in an entirely procedure based utilization analysis. If this option is used in Phase II, it will also be used in Phase III.

The Phase II Treatment Criteria and Norms reports are:

- Treatment Factors Analysis
- Peer Group Norms and Pattern Detail
- Provider Ratio Distribution
- Treatment Criteria Analysis

Report Definition: SUR-0820-A Treatment Factors Analysis

Part I Report Definition Information

Functional Area: SURS

Report Number: SUR-0820-A

Job Name: DSIBMU80

Report Title: Treatment Factors Analysis

Description of Information

The Treatment Factors Analysis Report provides an analysis of each procedure code used for a given diagnosis within a locality and provider type. The report displays a statistical distribution of the treatment characteristics regarding who (recipient's sex and age) is receiving the treatment, who (provider's specialty) is providing the treatment, and where (place of service) the procedure is being performed for each diagnosis.

Table 5.1 – User Options

Options	Description
Age Groups	Five age ranges are selected by the user for reporting. These age groups must be defined for this report regardless of whether the age group option is used in other Treatment Analysis Reports. Current age groups are **0-4, 5-12, 13-20, 21-64, and 65 +**

Purpose of Report

The information on the Treatment Factors Analysis Report does not directly affect the treatment exception process but can be used to document the need for medical policy claim audits when a problem area has been identified. Procedure codes could be limited to applicable recipient sex, age, provider specialties, and places of service.

Sort Sequence

Geographic region, provider type, diagnosis, procedure

Distribution

Distribution	Media	Copies	Frequency
IFSSA	CRLD		Annually
EDS	CRLD		Annually

Treatment Factors Analysis

Part II Report Definition Information

Functional Area: SURS

Report Number: SUR-0820-A

Detailed Field Definitions

Table 5.2 – Header Information

Field	Description
Period	The time frame reflected by the data on the report.
Report Locality	Identifies the peer group locality being reported.
Type	Identifies the peer group type being reported.
Diagnosis	Identifies the diagnosis being reported.

Table 5.3 – Detail Information

Field	Description
Procedure Code	The cross-reference procedure code and all procedure codes which have been assigned to the cross-reference value.
Total Svcs	Number of services provided for the procedure code for the stated diagnosis.
Pcnt Svcs by Sex Male and Female	The percentage of services provided for males and females respectively.
Pcnt Svcs by Age Group	A percentage distribution of services for each of five age groups.
Pcnt Svcs by Specialty	A percentage distribution of services by provider specialty beginning with the specialty code with the highest percentage.
SPC	Provider specialty code
PCNT	Percent of total services provided by this specialty
OTH	Represents other specialties not specifically listed on the report
PCNT	Percent of total services provided by specialties not listed
Pcnt Svcs by POS	A percentage distribution of services by place of service beginning with the individual place of service code with the highest percentage.
P	Place of service code.
PCNT	Percent of services provided at the indicated place of service.
O	Represents place of service codes not specifically listed on the report.
PCNT	Percent of services provided at places of service not listed.

Report Example: Treatment Factors Analysis

```
  REPORT:  SUR-0820- A                           INDIANA MEDICAID MANAGEMENT INFORMATION SYSTEM                              PAGE 99,999
 PROCESS:  SRGJQ082                                                                                                          RUN DATE: MM/DD/CCYY
LOCATION:  HUGP820B
                                                        TREATMENT FACTORS ANALYSIS REPORT                           PERIOD: MM/YY THRU MM/YY


REPORT LOCALITY - XXXX   - XXXXXXXXXXXXXXX             TYP - XXXX   - XXXXXXXXXXXXXXX

DIAGNOSIS - XXXXXX - XXXXXXXXXXXXXXXXXXXX


           -PCNT SVCS- -PCNT SVCS BY AGE GROUP-
PROC   NUMBER  --BY SEX---  XXX  XXX  XXX  XXX  XXX -------------------PCNT SVCS BY SPECIALTY------------------- -----PCNT SVCS BY POS-----
        OF      MALE  FEML  XXX  XXX  XXX  XXX  XXX SPEC  PCNT SPEC PCNT SPEC PCNT SPEC PCNT SPEC PCNT  OTH PCNT POS PCNT POS PCNT OTH PCNT
        SVCS

XXXXX  999,999 999.9 999.9 99.9 99.9 99.9 99.9 99.9 XXXX 999.9 XXXX 99.9 XXXX 99.9 XXXX 99.9 XXXX 99.9 9999 99.9 99  99.9 99  99.9 99  99.9
XXXXX  999,999 999.9 999.9 99.9 99.9 99.9 99.9 99.9 XXXX 999.9 XXXX 99.9 XXXX 99.9 XXXX 99.9 XXXX 99.9 9999 99.9 99  99.9 99  99.9 99  99.9
XXXXX  999,999 999.9 999.9 99.9 99.9 99.9 99.9 99.9 XXXX 999.9 XXXX 99.9 XXXX 99.9 XXXX 99.9 XXXX 99.9 9999 99.9 99  99.9 99  99.9 99  99.9
XXXXX  999,999 999.9 999.9 99.9 99.9 99.9 99.9 99.9 XXXX 999.9 XXXX 99.9 XXXX 99.9 XXXX 99.9 XXXX 99.9 9999 99.9 99  99.9 99  99.9 99  99.9
XXXXX  999,999 999.9 999.9 99.9 99.9 99.9 99.9 99.9 XXXX 999.9 XXXX 99.9 XXXX 99.9 XXXX 99.9 XXXX 99.9 9999 99.9 99  99.9 99  99.9 99  99.9
XXXXX  999,999 999.9 999.9 99.9 99.9 99.9 99.9 99.9 XXXX 999.9 XXXX 99.9 XXXX 99.9 XXXX 99.9 XXXX 99.9 9999 99.9 99  99.9 99  99.9 99  99.9

XXXXX  999,999 999.9 999.9 99.9 99.9 99.9 99.9 99.9 XXXX 999.9 XXXX 99.9 XXXX 99.9 XXXX 99.9 XXXX 99.9 9999 99.9 99  99.9 99  99.9 99  99.9
XXXXX  999,999 999.9 999.9 99.9 99.9 99.9 99.9 99.9 XXXX 999.9 XXXX 99.9 XXXX 99.9 XXXX 99.9 XXXX 99.9 9999 99.9 99  99.9 99  99.9 99  99.9
XXXXX  999,999 999.9 999.9 99.9 99.9 99.9 99.9 99.9 XXXX 999.9 XXXX 99.9 XXXX 99.9 XXXX 99.9 XXXX 99.9 9999 99.9 99  99.9 99  99.9 99  99.9
XXXXX  999,999 999.9 999.9 99.9 99.9 99.9 99.9 99.9 XXXX 999.9 XXXX 99.9 XXXX 99.9 XXXX 99.9 XXXX 99.9 9999 99.9 99  99.9 99  99.9 99  99.9
XXXXX  999,999 999.9 999.9 99.9 99.9 99.9 99.9 99.9 XXXX 999.9 XXXX 99.9 XXXX 99.9 XXXX 99.9 XXXX 99.9 9999 99.9 99  99.9 99  99.9 99  99.9
```

Report Definition: SUR-0270-A Peer Group Norms and Pattern Detail

Part I Report Definition Information

Functional Area:	SURS
Report Number:	SUR-0270-A
Job Name:	DSIBMU25
Report Title:	Peer Group Norms and Pattern Detail

Description of Information

The Peer Group Norms and Pattern Details Report displays the provider ratios of procedure use per 100 recipients being treated within a diagnosis category by a peer group. The ratios for all providers are averaged to determine the peer group mean. The deviation for each provider, above or below the mean is calculated and the value of an average or standard deviation is determined for all providers. The user supplies a standard deviation multiplier by which the value of the standard is multiplied to establish an allowable margin. The mean is increased and decreased by this allowable margin to establish the high and low utilization limits for the procedure code/diagnosis combination for the peer group. These limits are the high and low utilization norms.

The utilization ratios of the individual providers are shown in ascending order from left to right on the report along with their provider numbers. Providers whose ratios are above the high norm or less than the low norm are flagged as exceptions. High exceptions are indicated with an "H" and low exceptions are indicated with an "L".

Table 5.4 – User Options

Options	Description
Standard Deviations	The number of standard deviations to be used in computing the norm must be specified. The value of one standard deviation will be multiplied by the user-supplied allowance. Two is a common multiple. Currently set at **2**.
Minimum Recipients	User-specified number of recipients a provider must treat with the diagnosis/procedure combination before his activity will be included in the computation. Currently set at **5**.
Minimum Services	User-specified number of services for the diagnosis/procedure combination that each provider must perform before being included in the computation. Currently set at **1**.
Minimum Providers	The minimum number of providers who must meet the minimum recipients/services criteria before a norm will be computed on a diagnosis/procedure combination. Currently set at **10**.

Purpose of Report

When documenting a provider case for exceptional procedure over utilization, this report can be referenced for additional information concerning the utilization patterns of the other providers who used the diagnosis/procedure and the individual provider's actual rank among his peers.

Sort Sequence

Peer group, diagnosis group, procedure group, detail procedure

Distribution

Distribution	Media	Copies	Frequency
IFSSA	CRLD		Annually
EDS	CRLD		Annually

Peer Group Norms and Pattern Detail

Part II Report Definition Information

Functional Area: SURS

Report Number: SUR-0270-A

Detailed Field Definitions

Table 5.5 – Header Information

Field	Description
Standard Deviation Mult.	User controlled factor to determine how many standard deviations will be added to and subtracted from the mean to establish the high and low norms. Currently set at **2**.
Minimum Providers	The minimum number of providers in the peer group who performed the procedure for the diagnosis before a norm will be calculated. Default value is 3. Currently set at **10**.
Minimum Recipients	Minimum number of recipients treated for the diagnosis by a provider before he will be included in the norm calculation. Default value is 1. Currently set at **5**.
Minimum Services	Minimum number of services a provider must perform for the diagnosis/procedure before he will be included in the norm calculation. Default value is 1. Currently set at **1**.

Table 5.5 – Header Information

Field	Description
Report Location	Identifies the cross-reference locality of the peer group being reported.
Type	Identifies the cross-reference type of the peer group being reported.
Specialty	Identifies the provider specialty of the peer group being reported.
Diagnosis Group	Cross-reference diagnosis code and description being reported.
Procedure Group	Procedure code and description being reported. Ratios and norms for the cross-reference code appear first followed by the detail codes in the group on which norms were calculated.

Table 5.6 – Detail Information

Field	Description
Avg Bil/Sv	Average amount billed by the peer group for the procedure.
	Avg $/Svc = Total amt billed by peer group for diag/proc Total num svcs performed by peer group
Provs	The number of providers in the peer group performing the procedure for the stated diagnosis. To ensure an adequate data base when computing these norms, certain user-defined minimum standards must be met.
Mean	Average of all the individual provider ratios listed for the peer group.
Std Deviation	The value of one standard deviation. Standard deviation is the average of all provider variances above or below the peer group mean.
Norm - Low	Mean less "X" number of standard deviations where "X" is a user-supplied value.
Norm - High	Mean plus "X" number of standard deviations. where "X" is a user-supplied value.
Ratio	The ratio of services per 100 recipients with the stated procedure. The formula is: 100 x # of services for procedure # of recips with procedure
Provider	The provider ID number associated with the calculated ratio.
Flags	The number of providers who exceeded the norms, high or low, for the procedure. Exception providers are either flagged "H" or "L" on the detail lines.

Report Example: Peer Group Norms and Pattern Detail

```
   REPORT:   SUR-0270-Q                                INDIANAIM                                          PAGE 99,999
  PROCESS:   DSIBMU25                                                                                    RUN DATE: MM/DD/CCYY
 LOCATION:   HUGP270B                  PEER GROUP NORMS AND PATTERN DETAILS REPORT                       RUN TIME: 07:02:45

STANDARD DEVIATION MULTIPLIER - 99.99        MINIMUM PROVIDERS - 99,999  MINIMUM RECIPIENTS -  99,999        MINIMUM SERVICES -  99,999

REPORT—LOCATION - XXX XXXXXXX                   TYPE - XXXX XXXXXXXX                 SPECIALTY - XXXX XXXXXXXXXXXXXX

DIAGNOSIS GROUP - XXXXXX - XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX

    PROCEDURE GROUP - XXX-XXX – XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX                                  -------NORM-------

      XXXXXXXX       XXXXXXXXXXXXXXXXXXX                                AVG BIL/SV  PROVS     MEAN    STD DEV       LOW       HIGH

                                                                      999,999,999.99     9     999.99    999.99     999.99     999.99

     RATIO   PROVIDER      RATIO   PROVIDER      RATIO   PROVIDER         RATIO   PROVIDER        RATIO   PROVIDER  FLAGS

  99999.99   XXXXXXX    99999.99   XXXXXXX    99999.99   XXXXXXX       99999.99   XXXXXXX      99999.99   XXXXXXX
  99999.99   XXXXXXX    99999.99   XXXXXXX    99999.99   XXXXXXX       99999.99   XXXXXXX      99999.99   XXXXXXX

  99999.99   XXXXXXX    99999.99   XXXXXXX    99999.99   XXXXXXX       99999.99   XXXXXXX      99999.99   XXXXXXX
  99999.99   XXXXXXX    99999.99   XXXXXXX    99999.99   XXXXXXX       99999.99   XXXXXXX      99999.99   XXXXXXX
                                                                                                          999
```

Report Definition: SUR-0271-A Provider Ratio Distribution

Part I Report Definition Information

Functional Area:	SURS
Report Number:	SUR-0271-A
Job Name:	DSIBMU25
Report Title:	Provider Ratio Distribution

Description of Information

The Provider Ratio Distribution Report is a complementary report of the Peer Group Norms and Pattern Details Report. The report shows what ratio occurs at each of 8 user-supplied percentiles for a given peer group. A high and low percentile is selected. The values of the ratios at these percentiles are used as the high and low norms on the Provider Treatment Exception Reports. Any provider whose ratio falls outside the range will be assigned utilization weight for the exception.

The percentile report works in the following manner: Ratios are calculated for all providers in the peer group who meet the minimum activity requirements; should the peer group have 100 provider ratios for the procedure with percentiles set at 5%, 10%, , 90%, 95%, the report will show which ratio represented the lower 10% of the population, etc. Each percentile level includes all provider ratios in the preceding percentile(s). In other words, the ratio at the 10th percentile includes providers from the 5th percentile.

This report includes essentially the same information as the Peer Group Norms and Pattern Details Report with the following differences:

1. Providers included in the calculations are not shown with their individual ratios.
2. High and low norms are established based on different criteria; therefore, the values established will vary between the two reports.

The more providers in a particular peer group, the more meaningful the report. Provider activity minimums are established by the user for this report just as they are for the Peer Group Norms and Pattern Details Report.

Table 5.7 – User Options:

Options	Description
Percentiles	User-specified 8 percentiles for reporting. **5, 10, 25, 50, 95, 98**
Minimum Providers	The minimum number of providers who must meet the minimum activity requirements before a norm will be computed on a diagnosis/procedure combination. Currently set at **10**.

Table 5.7 – User Options:

Options	Description
Minimum Recipients	User-specified number of recipients a provider must treat with the diagnosis/procedure combination before his activity will be included in the computation. Currently set at **5**.
Minimum Services	User-specified number of services for the diagnosis/procedure combination that each provider must perform before being included in the computation. Currently set at **1**.

Purpose of Report

This report can be used in a manner similar to the Peer Group Norms and Pattern Details Report for comparing a provider to the activity of his peers. For states with substantial data, using the high and low norms established by percentiles of the provider population can be more accurate and more appropriate than by adding a fixed number of standard deviations. The distribution curve for percentiles is similar to that for norms except that the exception point is for X% of the providers rather than the calculated value of a standard deviation.

Table 5.8 – Header Information

Field	Description
Low Percentile	The user-selected percentile which determines the low norm for the peer group. Currently set at **5**.
High Percentile	The user-selected percentile which determines the high norm for the peer group. Currently set at **90**.
Minimum Providers	The minimum number of providers in the peer group who met the minimum activity requirements before a ratio distribution will be calculated. Default value is 3. Currently **10**
Minimum Recipients	Minimum number of recipients treated for the diagnosis by a provider before he will be included in the norm calculation. Default value is 1. Current value is **5**.
Minimum Services	Minimum number of services a provider must perform for the diagnosis/procedure before he will be included in the norm calculation. Default value is 1. Current value is **1**.
Report Location	Identifies the cross-reference locality of the peer group being reported.
Type	Identifies the cross-reference type of the peer group being reported.
Specialty	Identifies the cross-reference specialty of the peer group being reported.
Diagnosis Group	Cross-reference diagnosis code and description being reported.
Age Group	The recipient age group being reported if the user applies this option. Currently **off**.
Sex	The patient sex category being reported if the user applies this option. Currently **off**.

Table 5.8 – Header Information

Field	Description
Low	Indicates which of the percentiles has been selected by the user as the low norm. Currently set at **5**.
High	Indicates which of the percentiles has been selected by the user as the high norm. Currently set at **90**.
Percentiles	Eight percentile breaks selected by the user to reflect distribution of the provider ratios. **5, 10, 25, 50, 75, 90, 98**

Sort Sequence

Peer group, diagnosis group, procedure group, detail procedure

Distribution

Distribution	Media	Copies	Frequency
IFSSA	CRLD		Annually
EDS	CRLD		Annually

Provider Ratio Distribution

Part II Report Definition Information

Functional Area: SURS

Report Number: SUR-0271-A

Detailed Field Definitions

Table 5.9 – Detail Information

Field	Description
Procedure	Procedure code being reported. The cross-reference code appears first followed by the detail codes in the cross-reference group.
Description	The procedure description which corresponds to the code being reported.
Ratios	Ratio of services per 100 recipients which corresponds to each of the user selected percentiles.

Report Example: Provider Ratio Distribution

```
  REPORT:   SUR-0271-Q                               INDIANAIM                                PAGE 99,999
 PROCESS:   DSIBMU25                                                                          RUN DATE: MM/DD/CCYY
LOCATION:   HUGP270B                     PROVIDER RATIO DISTRIBUTION REPORT                   RUN TIME: 07:02:45

LOW PERCENTILE - 99.99  HIGH PERCENTILE – 99.99     MINIMUM PROVIDERS - 99999  MINIMUM RECIPIENTS -  99999 MINIMUM SERVICES -  99999

REPORT—LOCATION - XXX XXXXXXX                TYPE - XXXX XXXXXXXX                 SPECIALTY - XXXX XXXXXXXXXXXXXXX

DIAGNOSIS GROUP - XXXXXX - XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX
```

PROCEDURE	DESCRIPTION	PERCENTILES 99.9	99.9	99.9	99.9	99.9	99.9	99.9	99.9
XXXXXXXXXXX	XXXXXXXXXXXXXXXXXXXX	99999.99	99999.99	99999.99	99999.99	99999.99	99999.99	99999.99	99999.99
XXXXXXXXXXX	XXXXXXXXXXXXXXXXXXXX	99999.99	99999.99	99999.99	99999.99	99999.99	99999.99	99999.99	99999.99
XXXXXXXXXXX	XXXXXXXXXXXXXXXXXXXX	99999.99	99999.99	99999.99	99999.99	99999.99	99999.99	99999.99	99999.99
XXXXXXXXXXX	XXXXXXXXXXXXXXXXXXXX	99999.99	99999.99	99999.99	99999.99	99999.99	99999.99	99999.99	99999.99
XXXXXXXXXXX	XXXXXXXXXXXXXXXXXXXX	99999.99	99999.99	99999.99	99999.99	99999.99	99999.99	99999.99	99999.99
XXXXXXXXXXX	XXXXXXXXXXXXXXXXXXXX	99999.99	99999.99	99999.99	99999.99	99999.99	99999.99	99999.99	99999.99
XXXXXXXXXXX	XXXXXXXXXXXXXXXXXXXX	99999.99	99999.99	99999.99	99999.99	99999.99	99999.99	99999.99	99999.99

Report Definition: SUR-0290-A Treatment Criteria Analysis

Part I Report Definition Information

Functional Area:	SURS
Report Number:	SUR-0290-A
Job Name:	DSIBMU25
Report Title:	Treatment Criteria Analysis

Description of Information

The Treatment Criteria Analysis Report analyzes each procedure code used by the peer group for a diagnosis and determines its probability of occurrence based on the percent of recipients who received the procedure. The report establishes that; for this diagnosis treated by this provider peer group, these procedures should occur, these may or may not occur, and these occur only in rare cases. Criteria conditions of "required", "optional", and "never" are assigned based on user-defined percentages. For the purpose of example, 90% will be used as the upper bound parameter and 10% will be used as the lower bound parameter. Any procedure that occurs on 90% to 100% of the recipients with the diagnosis will be considered a "required" procedure. Any procedure used on 10% or less of the recipients will be considered a "never" procedure. Any procedure used in the range from 11% to 89% will be considered "optional".

Table 5.10 – User Options:

Options	Description
Criteria Probability	Upper bound and lowerbound percentages must be determined by the user. Currently **10** and **90**.

Purpose of Report

The Recipient Utilization Percent and the Average Services per Recipient, as shown on the Treatment Criteria Analysis Report, will appear on the Phase III Provider Treatment Analysis Report. The peer group statistics will be compared to the individual provider's utilization of each procedure for each diagnostic category. Criteria weight will be assigned if a provider over utilizes a "never" procedure or under utilizes a "required" procedure on the Provider Treatment Analysis Report in Phase III.

The Treatment Criteria Analysis Report can be used for additional documentation in provider case reviews. The number of providers in the peer group who used a procedure code can be referenced. In some cases of over utilization, the provider being investigated may be the only one who used the procedure. Therefore, this one provider has established the peer group's probability of occurrence. If the number of services was high and the provider treated a significant number of recipients with this diagnosis, the criteria condition for the peer group may be established as "optional". In this case, no

exception weight would be assigned. This type of information is significant when documenting that a provider is deviating from normal practice.

Based on the criteria conditions established on this report, prepayment or medical policy claim audits can be established to limit procedures to the treatment of certain diagnoses.

Sort Sequence

Peer group, diagnosis group, procedure group, detail procedure

Distribution

Distribution	Media	Copies	Frequency
IFSSA	CRLD		Annually
EDS	CRLD		Annually

Treatment Criteria Analysis

Part II Report Definition Information

Functional Area: SURS

Report Number: SUR-0290-A

Detailed Field Definitions

Table 5.11 – Header Information

Field	Description
Required Lower Bound	The percentage selected by the user to establish the lower limit for a "required" procedure. Currently set at **10**.
Not Required Upper Bound	The percentage selected by the user to establish the upper limit for a "never" procedure. Currently set at **90**.
Report Locality	Identifies the cross-reference locality of the peer group being reported.
Type	Identifies the cross-reference type of the peer group being reported.
Specialty	Identifies the cross-reference specialty of the peer group being reported.
Diagnosis	Cross-reference diagnosis code and description being reported.
Age Group	The recipient age group being reported if the user applies this option. Currently **off**.

Table 5.11 – Header Information

Field	Description
Sex	The recipient sex category being reported if the user applies this option. Currently **off**.
Number Provs Rpting Dx	The total number of providers in the peer group who treated recipients with the specified diagnostic category and the percentage of the total peer group represented.
Diagnosis Occurrence	The number of times the diagnosis occurred and the percentage of the total recipient count treated by the peer group who were treated for the diagnosis.

Table 5.12 – Detail Information

Field	Description
Line Number	Sequence number of procedure code cross-reference value. Ranking is by number of providers using this procedure code cross-reference.
Procedure	Procedure code. An "X" preceding the code indicates the cross-reference value which appears on the first line in the group. Detail codes appear in numeric order.
Description	Narrative description of the procedure. The cross-reference value description is user defined. Description for original value codes are taken from the procedure file.

Table 5.13 – Provider Util

Field	Description
Count	Number of providers within the peer group who performed services for each procedure code for recipients within the diagnostic category.
Pcnt	Percentage of the peer group who provided services for the stated diagnosis/procedure combination.

Table 5.14 – Recip Util

Field	Description
Count	Number of recipients who received the procedure for the stated diagnosis.
Pcnt	Percentage of recipients within the diagnostic category who received services for this procedure. This utilization percentage will establish the criteria condition for the procedure group.
Accum Prob	The probability of receiving a procedure in combination with those that appear above it.
Average Svcs	The average number of services received per recipient within the

Table 5.14 – Recip Util

Field	Description	
	diagnosis/procedure combination.	
Billed	The average amount billed per recipient for the stated diagnosis/procedure combination.	
Paid	The average amount paid per recipient for the diagnosis/procedure combination.	
Cri	The criteria condition (required, optional, or never), as determined by the probability of a recipient receiving services for the cross-referenced procedure within the diagnosis category based on the user supplied limits. These criteria conditions are assigned to the procedure cross-reference values, but not to the detail codes. The recipient utilization percentage for each procedure cross-reference code is the base for assigning the criteria condition.	
	REQ	Occurs for at least *X percent of all recipients within the diagnostic category.
	OPT	Occurs for less than *X percent of all recipients within the diagnostic category.
	NEV	Occurs for no more than *Y percent of all recipients within the diagnostic category. * The values of X and Y are user defined.

Report Example: Treatment Criteria Analysis

REPORT: SUR-0290-Q INDIANAIM PAGE 99,999
PROCESS: DSIBMU25 RUN DATE: MM/DD/CCYY
LOCATION: HUGP270B TREATMENT CRITERIA ANALYSIS REPORT RUN TIME: 07:02:45

PROBABILITIES - REQUIRED LOWER BOUND 999.99 NOT REQUIRED UPPER BOUND 999.99

REPORT-LOCALITY - XXXX XXXXXXXXXXXXXXX TYPE - XXXX XXXXXXXXXXXXXXX SPCECIALTY – XXXX - XXXXXXXXXXXXX

DIAGNOSIS - XXXXXX - XXXXXXXXXXXXXXXXXXXX

NUMBER OF PROVIDERS REPORTING THIS DIAGNOSIS - 999,999 - 999.99% DIAGNOSIS OCCURRENCE - 99,999 - 999.99%

LINE NO.	PROCEDURE	DESCRIPTION	PROVIDER-UTIL COUNT	PROVIDER-UTIL PCNT	CLIENT-UTIL COUNT	CLIENT-UTIL PCNT	ACCUM PROB	AVERAGE SVCS	AVERAGE BILLED	AVERAGE PAID	CRI
X	XXXXXXXX	XXXXXXXXXXXXXXXXXXXX	9999	999.99	9,999	999.99	9.999	999.99	999.99	99.99	XXX
X	XXXXXXXX	XXXXXXXXXXXXXXXXXXXX	9999	999.99	9,999	999.99	9.999	999.99	999.99	99.99	XXX
X	XXXXXXXX	XXXXXXXXXXXXXXXXXXXX	9999	999.99	9,999	999.99	9.999	999.99	999.99	99.99	XXX
X	XXXXXXXX	XXXXXXXXXXXXXXXXXXXX	9999	999.99	9,999	999.99	9.999	999.99	999.99	99.99	XXX
X	XXXXXXXX	XXXXXXXXXXXXXXXXXXXX	9999	999.99	9,999	999.99	9.999	999.99	999.99	99.99	XXX
X	XXXXXXXX	XXXXXXXXXXXXXXXXXXXX	9999	999.99	9,999	999.99	9.999	999.99	999.99	99.99	XXX
X	XXXXXXXX	XXXXXXXXXXXXXXXXXXXX	9999	999.99	9,999	999.99	9.999	999.99	999.99	99.99	XXX
X	XXXXXXXX	XXXXXXXXXXXXXXXXXXXX	9999	999.99	9,999	999.99	9.999	999.99	999.99	99.99	XXX
X	XXXXXXXX	XXXXXXXXXXXXXXXXXXXX	9999	999.99	9,999	999.99	9.999	999.99	999.99	99.99	XXX

Section 6: Phase III Reports and Windows

Overview

Phase III is the level of reporting for individual participants in the Title XIX program and is the quarterly portion of the RAMS system. Areas in which a provider or beneficiary has deviated significantly above or below his peer group's standards are indicated and weighted. From these exception indicators, the areas of potential abuse can be researched and documented at the claim detail level.

Indiana*AIM* incorporates 5 of the RAMS phase III major reporting subsystems into the quarterly SURS report generation. Those subsystems and reports are as follow:

- Provider Summary and Detail Reporting
- Recipient Summary Reporting
- Provider Treatment Analysis Reporting
- Hospital DRG Reporting
- Long Term Care Reporting

Provider Summary And Detail Reporting

Provider Summary Reporting

The Summary Profile Subsystem for Providers summarizes the data for selected report items, compares the individual's activity to the exception limits, assigns weight for those report items on which the provider has deviated, and then ranks the providers according to their exception weight.

The Peer Group Profile accumulates and summarizes the activities of all providers in a peer group. The peer group averages for the selected report line items are compared to the individual's activity summary on the All Provider Summary Report. Line items on which the provider deviates above or below the allowable values are flagged and an exception weight is assigned. If the provider's exception weight and volume of activity are high enough to place the provider in the user-defined top percentage of exception providers, a Provider Exception Summary Profile is generated for that provider. From each exception provider's summary report, the Provider Summary Profile Exception Ranking Report lists the providers in descending weight order. The individual with the highest weight is ranked first indicating that the degree of variance from the peer group average is the greatest for this provider.

A set of reports is generated for each Category of Service. The report line items in the activity summaries for each category should be applicable to the nature of services provided. The line items

for COS-Inpatient would be directed at length of stay, accommodation charges and use of ancillary codes. The line items for COS-Drug would apply to the dispensing of certain classes of drugs and narcotics, the percent of refills, average days supply, etc. Within Category of Service, different sets of line items can be established based on provider specialty groups.

Provider Detail Reporting

The Provider Detail Reports display claim details associated data for a reporting period specified by the user with a maximum of thirty six months.

Once a provider's problem areas are identified through a review of that provider's Summary Profile and Treatment Exception Reports, it is frequently necessary to research the History Details in order to document the specific instances of abuse. The reports identify the recipients who receive the services, when the services are performed, and what other services the recipient has received. Often a review of the History Detail uncovers certain patterns not detectable with other reports. Numerous select and sort options are available for focused reviews of specific areas of misutilization. Worksheet and Medical Records Request functions available through the History / Sample Inquiry Window provide data support for use in the onsite review process.

The following reports and windows are produced:

- Provider summary reporting
  - Provider to Peer Group Cross Reference
  - Provider Count by Peer Group
    1. Summary Category Code Activity Report
    2. Provider Exception Summary Profile Report
    3. All Provider Summary Report
    4. Selected Provider Summary Report
    5. Provider Group Profile Report
    6. Provider Exception Deselection Report
    7. Provider Peer Group Profile Report
    8. Provider Exception Statistics Report
    9. Provider Summary Profile (Forced) Report
    10. Provider Summary Profile Exception Ranking Report
- Provider detail reporting
  - Statistical Summary for Sample Request Window
  - SURS Provider History / Sample Request Window
  - SUR Claims Inquiry Window
  - Provider Select Window

- Selected Provider Detail Report
- SURS Provider Detail History Summary
- SUR Non-Institutional Worksheet
- SUR Institutional Worksheet (*not currently produced.)*
- Medical Records Request

Report Definition: SUR-1550-Q Provider to Peer Group Cross Reference

Part I Report Definition Information

Functional Area:	SURS
Report Number:	SUR-1550-Q
Job Name:	SRGJQ150
Report Title:	Provider to Peer Group Cross Reference

Description of Information on the Report

The Provider to Peer Group Cross-Reference Report displays the peer group(s) in which each provider is active. For those providers who have activity in more than one category of service, the appropriate peer grouping for each category of service is reported.

Purpose of Report:

The Provider to Peer Group Cross-Reference Report can be used to identify the peer group(s) in which a provider is active. The Summary Profile reports are in peer group/provider number sequence; in order to find a specific provider it is necessary to know the peer group and the SUR-1550-Q provides a quick reference.

Sort Sequence:

Provider number

Distribution

Distribution	Media	Copies	Frequency
EDS	CRLD		Quarterly
IFSSA	CRLD		Quarterly

Provider to Peer Group Cross-Reference

Part II Report Definition Information

Functional Area: SURS

Report Number: SUR-1550-Q

Detailed Field Definitions

Table 6.1 – Field Description

Field	Description
Period	The period for the data extracted and summarized on this report.
Provider	The provider's Medicaid identification number
COS	The SURS category of service in which the provider's summary profile activity is reported
LOC	The cross-reference locality code used in determining the provider's reporting peer group
TYP	The cross-reference type code used in determining the provider's reporting peer group
SPC	The cross-reference specialty code used in determining the provider's reporting peer group. Not currently used.
SIZE	The cross-reference bed size grouping (for inpatient hospital providers) used in determining the provider's reporting peer group
G/I	Group indicator ('G' = group provider, 'I' = individual)
Number of Providers Processed	The cumulative total of all providers reported

Report Example: Provider to Peer Group Cross-Reference

```
 REPORT:    SUR-1550-Q                          INDIANAIM                          PAGE NUM: 99,999
 PROCESS:   SRGJQ150                                                               RUN DATE: MM/DD/CCYY
LOCATION:   SRGP1552                PROVIDER TO PEER GROUP CROSS-REFERENCE REPORT
                                         PERIOD: MM/CCYY THRU MM/CCYY
```

PROVIDER	COS	LOC	TYP	SPC	SIZE	G/I	PROVIDER	COS	LOC	TYP	SPC	SIZE	G/I
999999999	06	00S	T31	S328	N/A	I	999999999	06	00S	T31	S328	N/A	I
999999999	06	00S	T31	S328	N/A	I	999999999	06	00S	T31	S328	N/A	I
999999999	06	00S	T31	S328	N/A	I	999999999	06	00S	T31	S328	N/A	I
999999999	06	00S	T31	S328	N/A	I	999999999	06	00S	T31	S328	N/A	I
999999999	06	00S	T31	S328	N/A	I	999999999	06	00S	T31	S328	N/A	I
999999999	06	00S	T31	S328	N/A	I	999999999	06	00S	T31	S328	N/A	I
999999999	06	00S	T31	S328	N/A	I	999999999	06	00S	T31	S328	N/A	I
999999999	06	00S	T31	S328	N/A	I	999999999	06	00S	T31	S328	N/A	I
999999999	06	00S	T31	S328	N/A	I	999999999	06	00S	T31	S328	N/A	I
999999999	06	00S	T31	S328	N/A	I	999999999	06	00S	T31	S328	N/A	I
999999999	06	00S	T31	S328	N/A	I	999999999	06	00S	T31	S328	N/A	I
999999999	06	00S	T31	S328	N/A	I	999999999	06	00S	T31	S328	N/A	I
999999999	06	00S	T31	S328	N/A	I	999999999	06	00S	T31	S328	N/A	I
999999999	06	00S	T31	S328	N/A	I	999999999	06	00S	T31	S328	N/A	I
999999999	06	00S	T31	S328	N/A	I	999999999	06	00S	T31	S328	N/A	I

NUMBER OF PROVIDERS PROCESSED 9,999,999

Report Definition: SUR-1560-Q Provider Count by Peer Group

Part I Report Definition Information

Functional Area:	SURS
Report Number:	SUR-1560-Q
Job Name:	SRGJQ150
Report Title:	Provider Count by Peer Group

Description of Information

The Provider Count by Peer Group Report displays all peer groups within each category of service along with a count of the number of providers active in each peer group. This report is a summary of the information reported on the Provider to Peer Group Cross-Reference Report.

Purpose of Report:

The Provider Count by Peer Group Report allows the user to analyze the appropriateness of the peer group structure or to evaluate the effect of peer group changes before the changes are implemented.

Sort Sequence:

Category of service, locality, type, specialty

Distribution

Distribution	Media	Copies	Frequency
EDS	CRLD		Quarterly
IFSSA	CRLD		Quarterly

Provider Count by Peer Group

Part II Report Definition Information

Functional Area: SURS

Report Number: SUR-1560-Q

Detailed Field Definitions

Table 6.2 – Field Description

Field	Description
Period	The period for the data extracted and summarized on this report.
Prov	The provider's Medicaid identification number
COS	The SURS category of service in which the provider's summary profile activity is reported
LOC	The cross-reference peer group locality code and definition
TYP	The cross-reference peer group type code and definition
SPC	The cross-reference peer group specialty code and definition
SIZE	The cross-reference peer group bed size grouping (for inpatient hospital providers). Not currently used.
G/I	The peer group 'group status' ('G' = group provider, 'I' = individual)
Count	The number of providers with activity on the SURS master file assigned to this peer group

Report Example: Provider Count by Peer Group

REPORT: SUR-1560-Q INDIANAIM PAGE NUM: 99,999
PROCESS: SRGJQ150 RUN DATE: MM/DD/CCYY
LOCATION: SRGP1552

PROVIDER TO PEER GROUP CROSS-REFERENCE REPORT
PERIOD: MM/CCYY THRU MM/CCYY

CATEGORY OF SERVICE 99

LOC	LOCATION DESCRIPTION	TYPE	TYPE DESCRIPTION	SPEC	SPEC DESCRIPTION	SIZE	G/I	COUNT
IN	INDIANA	T01	Hospital	S010	ACUTE CARE HOSPOTAL	N/A	G	21
				S011	PSYCHIATRIC HOSPOTAL	N/A	I	121
				S012	REHABILITATION HOSPOTAL	N/A	G	4
		T02	Ambulatory Surgical Cent	S020	AMBULATORY SURGICAL CENT	N/A	G	10
IN	GRAY	T01	Hospital	S010	ACUTE CARE HOSPOTAL	N/A	G	21
				S011	PSYCHIATRIC HOSPOTAL	N/A	I	121
				S012	REHABILITATION HOSPOTAL	N/A	G	14
		T02	Ambulatory Surgical Cent	S020	AMBULATORY SURGICAL CENT	N/A	G	10
IN	SOUTH BEND	T01	Hospital	S010	ACUTE CARE HOSPOTAL	N/A	G	21
				S011	PSYCHIATRIC HOSPOTAL	N/A	I	121
				S012	REHABILITATION HOSPOTAL	N/A	G	15
		T02	Ambulatory Surgical Cent	S020	AMBULATORY SURGICAL CENT	N/A	G	110

Report Definition: SUR-0222-Q Summary Category Code Activity

Part I Report Definition Information

Functional Area:	SURS
Report Number:	SUR-0222-Q
Job Name:	DSIBMU21
Report Title:	Summary Category Code Activity

Description of Information

The Summary Category Code Activity Report provides a total count of the active details for every extract code used in the summary profile line item building process.

Purpose of Report

This report is used to analyze the volume of use of standard extract codes and summary extract codes that are defined on the Summary Line Item Control File. Codes having no activity or low volume are evaluated for possible removal from the line items so that they can be replaced by codes that will generate more meaningful data.

Sort Sequence

Category of service, category code

Distribution

Distribution	Media	Copies	Frequency
EDS	Hardcopy	One	Quarterly

Summary Category Code Activity

Part II Report Definition Information

Functional Area: SURS

Report Number: SUR-0222-Q

Detailed Field Definitions

Table 6.3 – Header Information

Field	Description
Category of Service	The category of service for which the extract code activity is reported.
Report Sequence	The report sequence for which the extract code activity is reported.
Specialties	The specialty code (s) for which the extract code activity is reported.

Table 6.4 – Detail Information

Field	Description
Extract Code	The summary extract code requested as defined on the Summary Profile Line Item Control File.
From Value	The 'from' value used for the extract code range of values.
To Value	The 'to' value used for the extract code range of values.
Matrix Cell	The category code assigned to this extract code as defined in the Summary Profile Line Item Control File.
Active Details	The number of times the extract code within the category code occurred on the claims being reported in the summary profiles.

Report Example: Summary Category Code Activity

```
  REPORT:   SUR-0222-Q                              INDIANAIM                                PAGE:      99,999
 PROCESS:   DSIBMU21                                                                       RUN DATE: MM/DD/CCYY
LOCATION:   HUGS221B                        SUMMARY CATEGORY CODE ACTIVITY REPORT         RUN TIME: 14:42:48

                                            CATEGORY OF SERVICE - 01 - INPATIENT
                        REPORT SEQUENCE – A          SPECIALTIES -    S010
```

STANDARD/SUMMARY EXTRACT CODE	FROM VALUE	TO VALUE	MATRIX CELL	ACTIVE DETAILS
IP				456
MD				500
CLM-TSP	I-0240	I-0409	61	395
CLM-TSP	I-0460	I-0469	61	3,709
CLM-TSP	I-0610	I-0639	61	2,132
CLM-TSP	I-0710	I-0719	61	145
CLM-TSP	I-0730	I-0749	61	114
CLM-TSP	I-0920	I-0929	61	88
DOW-TSP	FRI-0450	FRI-0459	14	120
DOW-TSP	SAT-0450	SAT-0459	14	17
DRG	0468	0468	71	11
DRG	0476	0477	71	0
DRG	0469	0470	72	23
DRG	0700	0716	73	17
DRG	0602	0619	74	44
DRG	0621	0624	74	35
DRG	0626	0628	74	0
DRG	0630	0630	74	0
DRG	0635	0635	74	45
DRG	0637	0641	75	25
DRG	0620	0620	75	12
DRG	0625	0625	75	122

Report Definition: SUR-3200-Q Provider Summary Profile (Exceptions)

Part I Report Definition Information

Functional Area: SURS

Report Number: SUR-3200-Q

Job Name: DSIBMU31

Report Title: Provider Summary Profile (Exceptions)

Description of Information

The Provider Exception Summary Profile Report provides the user with a statistical summary of a provider's activity during the time periods that are being reported. The purpose of this report is to monitor significant characteristics of provider quality and quantity of medical care based on user-defined parameters. Exceptional patterns of practice are identified based on either a percentage difference from the peer group average, a fixed value, or a standard deviation. Exception weight is assigned based on the level of deviation. This report is produced when a provider's exception weight places him within the top X% of exception providers within his category of service and the provider meets the user-defined minimums for exception reporting.

Purpose of Report

A provider's summary profile is used to perform the initial review of the provider's practice. The key to effective use of the summary profile is to have appropriate parameters with line items designed to detect potential areas of abuse by the providers. The limits should be defined sufficiently above or below the peer group averages so that only those providers who have deviated most significantly are flagged. Providers are not flagged for exception on line items that have not been assigned an exception limit. A limit is established for every selected parameter to detect misutilization.

Sort Sequence

Category of service, provider peer group, provider number

Distribution

Distribution	Media	Copies	Frequency
EDS	CRLD		Quarterly
IFSSA	CRLD		Quarterly

Provider Exception Summary Profile

Part II Report Definition Information

Functional Area: SURS

Report Number: SUR-3200-Q

Detailed Field Definitions

Table 6.5 – Field Description

Field	Description
Cat Svc Rpt Seq	This field displays the report sequence within category of service when the multiple report sequence option is used.
Period	The time frame reflected by the data on the report.
Program	The assistance program for which data is reported.
Category of Service	The provider's medical care category and description being reported.
Report Location	The provider's peer group locality code and description.
Report Type	The provider's peer group type code and description.
Report Spec	The provider's peer group specialty code and description
Report Size	The provider’s peer group bed size. Not currently used.
Report Org. Type	The provider’s peer group organizational type when this field is used
Report Facility Type	The provider’s peer group facility type when this field is used
Detail Location	The provider's original location code and description.
Detail Type	The provider's original type code and description.
Detail Spec	The provider's original specialty code and description.
Detail Size	The provider’s original bed size. Not currently used.
Detail Org. Type	The provider’s original organization type when this field is used.
Detail Facility Type	The provider’s original facility type when this field is used.
Prov	Information identifying the provider including number, last, first name, middle initial, and address.
G/I	Indicates whether the provider is a group or individual provider (‘G’ = group; ‘I’ = individual).
Reference Period	The reporting period selected by the user as the period on which peer group averages are to be computed for comparison to the provider's activity for determination of exceptions. P1 is the most recent period.
FYTD Period	The fiscal year-to-date period that defines data to be included in the FYTD totals at the bottom of the report. The user determines the month to be used for the fiscal year-to-date accumulations. The dates displayed in this field begin with the first month of the fiscal year and end with the last month of data being reported. Currently set at **July**.

Table 6.5 – Field Description

Field	Description
Ref Period Peer Grp Count	The total number of providers in the peer group who have data in the reference period, and whose activity is used to compute the peer group averages.
Tot Wgt	The provider's total exception weight for all reporting periods. This weight represents a measure of deviation from the expected values for all data elements noted as exceptions.
Period Weight Multipliers	A factor selected by the user by which the computed **0.5, 0.7, 1.0, 1.0, 1.0**exception weight is multiplied for each corresponding reporting period. This enables the user to effect higher weight on exception items in a selected reporting period such as the reference period, and lower weight in periods where the data may not be as complete due to the claim filing deadline. This factor is a whole number and one decimal place. There are five period weight multipliers.
Minimums for Exception Reporting [Billed **15000**, Recipients **60**, Claims **60**, Services **60**]	User selected activity minimums that must be met before a provider is considered an exception provider. A provider who does not meet these minimums is not reported on the 320 report. These minimums should be used to prevent the generation of 320 reports for providers whose low volume of activity would not warrant investigation. Minimum values for number of dollars billed, recipients, claims, and services can be established by the user to ensure that low volume providers are not considered exceptions. Low volume providers receive high exception weight because their averages, percentages, and services per recipient are distorted simply because they perform very few services. By setting these minimums at realistic levels, the exception reports produced are more likely to represent valid cases of abuse or misutilization. The values set apply to the provider's activity during the reference period. One set of minimums is used for all categories of service.
Reporting Period Headers	The month(s) and year(s) for beginning and ending dates for reporting periods 1 through 5.
Activity Summary	A list of user-defined report elements that apply to the report image in which the provider has activity. Exception limits established by the user for each parameter appear immediately following the line item to which it pertains. Up to 99 line items can be selected by the user according to current needs. Each Category of Service should have its own set of line items applicable to the type of medical care being provided. Within each Category of Service, nine different sets of line items are available. The ninth set is considered the 'default' activity summary and applies to all providers in the Category of Service whose specialty is not specified elsewhere.
Line Item Number	The line item number as defined on the 40 control file.
Line Item Description	The line item description as defined on the 40 control file.

Table 6.5 – Field Description

Field	Description
Peer Trend	A measure of the change in totals over the five reporting periods for the peer group. TREND = $\frac{100 \text{ X } (2P1 + P2 - P4 - 2P5)}{2 \text{ X } (P1 + P2 + P3 + P4 + P5)}$ P1 represents the most recent reporting period, P2 represents the next most recent reporting period, etc. If less than five periods are reported, the value of unused periods is zero, therefore; the result of the trend calculation may not be valid. The Trends field can be suppressed, if the user determines this information is of little value and/or may be misleading.
Indiv Trends	A measure of the change in totals over the five reporting periods for the individual provider.
Reference Period Weight	A mathematical calculation of the degree of deviation from the expected (peer group) values for each line item in the reference period on which the provider has exceptional activity. WEIGHT = 100 X $\frac{(\text{INDIV VALUE - PGA})}{\text{PGA}}$ The result of the calculation is then multiplied by the appropriate period weight multiplier. Example: Peer group average = 3 Individual's value = 9 Period Weight Multiplier = Default value 1.0 $\frac{(9 - 3)}{3}$ = 2 X 100 = 200 X 1.0 = 200
Per Gp Avg	The average value of each data element for the entire peer group in the reference period based on the information appearing on the Provider Peer Group Profile Report.
Line Item Values [Periods 1-5]	The computed values for individual reporting periods (1-5) for each line item.
Exception Indicator	'Flags' that appear next to the value of a line item when a provider deviates outside the range of acceptable values as established by the user. An exception can occur only on line items for which the user sets limits. 'H' is the resulting value for the provider greater than the high limit. 'L' is the resulting value for the provider less than the low limit.
Total Exceptions	The total number of exceptions for all reporting periods. The values displayed in the remainder of the line represent the number of exceptions occurring in each reporting period, 1-5.
Total Weight	The accumulated exception weight for all reporting periods. The values displayed in the remainder of the line represent the weight occurring in each reporting period, 1-5.

Table 6.6 – FYTD Totals (Title XIX and XVIII)

Field	Description
No Svcs	Total number of services performed by this provider for the Title XIX and XVIII payment classes.
Amt Billed	Total dollars billed for services performed by this provider for the Title XIX and XVIII payment classes.
Amt Allowed	Total dollars allowed for services performed by this provider for the Title XIX and XVIII payment classes.
Amt Paid	Total dollars paid for services performed by this provider for the Title XIX and XVIII payment classes.
Pct Pd/Bill	Percentage of the amount billed that was paid for services in the Title XIX and XVIII payment classes.

Report Example: Provider Exception Summary Profile

```
  REPORT:  SUR-3200- Q                              INDIANAIM
 PROCESS:  DSIBMU31                                                                    PAGE NUM: 99,999
LOCATION:  HUGS320B                  PROVIDER SUMMARY PROFILE REPORT (EXCEPTIONS)      RUN DATE: 05/08/99
                                                                                      RUN TIME: 14:37:56
CAT SVC-RPT SEQ 06-A               INDIANA MEDICAID MANAGEMENT INFORMATION SYSTEM

                                                                                 PERIOD:  MM/YY THRU MM/YY
PROGRAM: MEDICAID                      CATEGORY OF SERVICE – 06 - PHYSICIAN

REPORT--LOCATION – L46 - LAPORTE            TYPE – T31 - Physician              SPEC          - S332 - ENT
SIZE N/A    ORG. TYP    FACILITY TYPE
DETAIL--LOCATION - 46    - LaPorte          TYPE – 031 - Physician              SPEC          - 332  - OTOLOGIST, LARYNGOLOGIST
SIZE 00000  ORG. TYP    FACILITY TYPE

PROV     -  999999999      SMITH K BEN MD                        1509  STATE STREET  #2A    LAPORTE                  IN  45647 G/I G

REFERENCE PERIOD:  MMM YY-MMM YY    FYTD PERIOD -  MMM YY-MMM YY  REFERENCE PERIOD PEER GROUP COUNT -      99,999    TOT WGT -  999,999

PERIOD WEIGHT MULTIPLIERS: 99.9, 99.9, 99.9, 99.9, 99.9
MINIMUMS FOR EXCEPTION REPORTING    BILLED  99999   RECIPIENTS     99999   CLAIMS  99999    SERVICES  99999

                                  -----TRENDS----- -REFERENCE PERIOD-    MMM YY    MMM YY    MMM YY    MMM YY    MMM YY
----------ACTIVITY SUMMARY----------      PEER    INDIV  WEIGHT PER GP AVG    MMM YY    MMM YY    MMM YY    MMM YY    MMM YY

01-Amount Billed                    X999.99  X999.99  99,999  99,999.99  999999.99  999999.99  999999.99  999999.99  999999.99 X
02-Amount Paid                      X999.99  X999.99  99,999  99,999.99  999999.99  999999.99  999999.99  999999.99  999999.99 X
03-Percent Paid of Billed           X999.99  X999.99  99,999  99,999.99  999999.99  999999.99  999999.99  999999.99  999999.99 X
04-Number of Claims                 X999.99  X999.99  99,999  99,999.99  999999.99  999999.99  999999.99  999999.99  999999.99 X
05-Number of Recipients             X999.99  X999.99  99,999  99,999.99  999999.99  999999.99  999999.99  999999.99  999999.99 X
06-Avg Amt Billed/Recipient         X999.99  X999.99  99,999  99,999.99  999999.99  999999.99  999999.99  999999.99  999999.99 X
07-Avg Amt Paid/Recipient           X999.99  X999.99  99,999  99,999.99  999999.99  999999.99  999999.99  999999.99  999999.99 X

TOTAL EXCEPTIONS         999,999                                              99,999     99,999     99,999     99,999     99,999
TOTAL WEIGHT             999,999                                          99,999,999 99,999,999 99,999,999 99,999,999 99,999,999

FYTD TOTALS TITLE XIX     NO SVCS   9999  AMT BILLED 999,999.99    AMT ALLOWED  999,999.99  AMT PAID 999,999.99  PCT PAID/BILLED 999.99
            TITLE XVIII             9999             999,999.99                 999,999.99           999,999.99                  999.99
```

Report Definition: SUR-3210-Q All Provider Summary Profile

Part I Report Definition Information

Functional Area:	SURS
Report Number:	SUR-3210-Q
Job Name:	DSIBMU31
Report Title:	Provider Summary Profile (Total List)

Description of Information

The Provider Summary Profile (Total List) Report provides the user with a summary profile for **all** providers in each category of service who meet activity minimums during the reference period. This report is identical in content to the Provider Exception Summary Profile Report, but because it reports on every provider (who met the minimums), it is normally much larger in volume.

Purpose of Report

A provider's summary profile is used to perform the initial review of the provider's practice. The key to effective use of the summary profile is to have appropriate parameters with line items designed to detect potential areas of abuse by the providers. The limits should be defined sufficiently above or below the peer group averages so that only those providers who have deviated most significantly are flagged. Providers are not flagged for exception on line items which have not been assigned an exception limit. A limit is established for every selected parameter to detect misutilization.

Sort Sequence

Category of service, provider peer group, provider number

Distribution

Distribution	Media	Copies	Frequency
EDS	CRLD		Quarterly, on request
IFSSA	CRLD		Quarterly, on request

Provider Summary Profile (Total List) Report

Part II Report Definition Information

Functional Area:	SURS
Report Number:	SUR-3210-Q

Detailed Field Definitions

The report field descriptions for the Provider Summary Profile (Total List) Report are identical to those of the Provider Exception Summary Profile Report. Please refer to the report field descriptions section for Provider Exception Summary Profile Report for this information.

Report Example: Provider Summary Profile (Total List)

```
  REPORT:  SUR-3210- Q                              INDIANAIM
 PROCESS:  DSIBMU31                                                                  PAGE NUM: 99,999
LOCATION:  HUGS320B                  PROVIDER SUMMARY PROFILE REPORT (TOTAL LIST)    RUN DATE: 05/08/99
                                                                                     RUN TIME: 14:37:56
CAT SVC-RPT SEQ 06-A               INDIANA MEDICAID MANAGEMENT INFORMATION SYSTEM

                                                                                PERIOD:  MM YY THRU MM YY
PROGRAM: MEDICAID                       CATEGORY OF SERVICE – 06 - PHYSICIAN

REPORT--LOCATION – ALL - ALL               TYPE – T31 - Physician               SPEC          - S332 - ENT
SIZE N/A    ORG. TYP    FACILITY TYPE
DETAIL--LOCATION - 46    - LaPorte         TYPE – 031 - Physician               SPEC          - 332  - OTOLOGIST, LARYNGOLOGIST
SIZE 00000  ORG. TYP    FACILITY TYPE

PROV     -  999999999      SMITH K BEN MD                          1509  STATE STREET  #2A    LAPORTE                 IN  45647 G/I G

REFERENCE PERIOD:  MMM YY-MMM YY    FYTD PERIOD -  MMM YY-MMM YY  REFERENCE PERIOD PEER GROUP COUNT -      99,999    TOT WGT -  999,999

PERIOD WEIGHT MULTIPLIERS: 99.9, 99.9, 99.9, 99.9, 99.9
MINIMUMS FOR EXCEPTION REPORTING    BILLED  99999   RECIPIENTS     99999   CLAIMS  99999    SERVICES  99999

                                  -----TRENDS----- -REFERENCE PERIOD-    MMM YY    MMM YY    MMM YY    MMM YY    MMM YY
----------ACTIVITY SUMMARY----------      PEER    INDIV  WEIGHT PER GP AVG    MMM YY    MMM YY    MMM YY    MMM YY    MMM YY

01-Amount Billed                    X999.99  X999.99  99,999  99,999.99  999999.99  999999.99  999999.99  999999.99  999999.99 X
02-Amount Paid                      X999.99  X999.99  99,999  99,999.99  999999.99  999999.99  999999.99  999999.99  999999.99 X
03-Percent Paid of Billed           X999.99  X999.99  99,999  99,999.99  999999.99  999999.99  999999.99  999999.99  999999.99 X
04-Number of Claims                 X999.99  X999.99  99,999  99,999.99  999999.99  999999.99  999999.99  999999.99  999999.99 X
05-Number of Recipients             X999.99  X999.99  99,999  99,999.99  999999.99  999999.99  999999.99  999999.99  999999.99 X
06-Avg Amt Billed/Recipient         X999.99  X999.99  99,999  99,999.99  999999.99  999999.99  999999.99  999999.99  999999.99 X
07-Avg Amt Paid/Recipient           X999.99  X999.99  99,999  99,999.99  999999.99  999999.99  999999.99  999999.99  999999.99 X

TOTAL EXCEPTIONS        999,999                                              99,999     99,999     99,999     99,999     99,999
TOTAL WEIGHT            999,999                                          99,999,999 99,999,999 99,999,999 99,999,999 99,999,999

FYTD TOTALS TITLE XIX     NO SVCS   9999  AMT BILLED 999,999.99    AMT ALLOWED  999,999.99  AMT PAID 999,999.99  PCT PAID/BILLED 999.99
            TITLE XVIII             9999             999,999.99                 999,999.99           999,999.99                  999.99
```

Report Definition: SUR-3220-Q Selected Provider Summary Profile

Part I Report Definition Information

Functional Area:	SURS
Report Number:	SUR-3220-Q
Job Name:	DSIBMU31
Report Title:	Selected Provider Summary Profile

Description of Information

The Selected Provider Summary Profile Report gives the user the option of selecting providers for which a summary profile is produced regardless of whether or not the provider had exceptions. The activity minimums are not applied to selected providers. The format of this report is exactly like that of the Provider Exception Summary Profile Report.

Purpose of Report

A Selected Provider Summary Profile Report may be requested to ensure that a Profile will be produced for providers who are targeted for review from sources other than the Exception Ranking Report. This report is redundant if the All Provider Summary Profile Report is routinely produced.

Sort Sequence

Category of service, provider peer group, provider number

Distribution

Distribution	Media	Copies	Frequency
EDS	CRLD		Quarterly, on request
IFSSA	CRLD		Quarterly, on request

Selected Provider Summary Profile

Part II Report Definition Information

Functional Area:	SURS
Report Number:	SUR-3220-Q

Detailed Field Definitions

The report field descriptions for the Selected Provider Summary Profile Report are identical to those of the Provider Exception Summary Profile Report. Please refer to the report field descriptions section for Provider Exception Summary Profile Report for this information.

Report Example: Selected Provider Summary Profile

```
  REPORT:  SUR-3220- Q                              INDIANAIM
 PROCESS:  DSIBMU31                                                                  PAGE NUM: 99,999
LOCATION:  HUGS322B                  SELECTED PROVIDER SUMMARY PROFILE REPORT       RUN DATE: 05/08/99
                                                                                    RUN TIME: 14:37:56
CAT SVC-RPT SEQ 06-A              INDIANA MEDICAID MANAGEMENT INFORMATION SYSTEM

                                                                          PERIOD:  MM YY THRU MM YY
PROGRAM: MEDICAID                      CATEGORY OF SERVICE – 06 - PHYSICIAN

REPORT--LOCATION – IN - INDIANA            TYPE – T31 - Physician              SPEC          - S332 - ENT
SIZE N/A    ORG. TYP    FACILITY TYPE
DETAIL--LOCATION - 46    - LaPorte         TYPE – 031 - Physician              SPEC          - 332  - OTOLOGIST, LARYNGOLOGIST
SIZE 00000  ORG. TYP    FACILITY TYPE     G/I

PROV     -  999999999      SMITH K BEN MD                        1509  STATE STREET  #2A    LAPORTE                 IN  45647 G/I G

REFERENCE PERIOD:  MMM YY-MMM YY    FYTD PERIOD -  MMM YY-MMM YY  REFERENCE PERIOD PEER GROUP COUNT -      99,999    TOT WGT -  999,999

PERIOD WEIGHT MULTIPLIERS: 99.9, 99.9, 99.9, 99.9, 99.9

                                    -----TRENDS-----  -REFERENCE PERIOD-    MMM YY    MMM YY    MMM YY    MMM YY    MMM YY
----------ACTIVITY SUMMARY----------      PEER    INDIV  WEIGHT PER GP AVG    MMM YY    MMM YY    MMM YY    MMM YY    MMM YY

01-Amount Billed                    X999.99  X999.99  99,999  99,999.99  999999.99  999999.99  999999.99  999999.99  999999.99 X
02-Amount Paid                      X999.99  X999.99  99,999  99,999.99  999999.99  999999.99  999999.99  999999.99  999999.99 X
03-Percent Paid of Billed           X999.99  X999.99  99,999  99,999.99  999999.99  999999.99  999999.99  999999.99  999999.99 X
04-Number of Claims                 X999.99  X999.99  99,999  99,999.99  999999.99  999999.99  999999.99  999999.99  999999.99 X
05-Number of Recipients             X999.99  X999.99  99,999  99,999.99  999999.99  999999.99  999999.99  999999.99  999999.99 X
06-Avg Amt Billed/Recipient         X999.99  X999.99  99,999  99,999.99  999999.99  999999.99  999999.99  999999.99  999999.99 X
07-Avg Amt Paid/Recipient           X999.99  X999.99  99,999  99,999.99  999999.99  999999.99  999999.99  999999.99  999999.99 X

TOTAL EXCEPTIONS         999,999                                              99,999     99,999     99,999     99,999     99,999
TOTAL WEIGHT             999,999                                          99,999,999 99,999,999 99,999,999 99,999,999 99,999,999

FYTD TOTALS TITLE XIX     NO SVCS   9999  AMT BILLED 999,999.99    AMT ALLOWED  999,999.99  AMT PAID 999,999.99  PCT PAID/BILLED 999.99
            TITLE XVIII             9999             999,999.99                 999,999.99           999,999.99                  999.99
```

Report Definition: SUR-3230-Q Provider Group Summary Profile

Part I Report Definition Information

Functional Area:	SURS
Report Number:	SUR-3230-Q
Job Name:	DSIBMU31
Report Title:	Provider Group Summary Profile

Description of Information

The Provider Group Summary Profile Report allows the user to obtain an exception profile on the billing provider groups or clinics. Whereas the other provider summary reports deal with the performing provider practices, the provider group profiles report all activity billed under the group number regardless of which provider in the group actually rendered the service. This report is identical in format to the Provider Summary Profile Report.

Purpose of Report

A provider group summary profile is used to perform the initial review of the group provider's practice, regardless of which provider in the group actually render the services. Utilization of the group profile report provides a comprehensive picture of the entire group's billing / practice patterns. If, upon initial review of the group's practice, one or two providers within the group are suspected of contributing primarily to the group's exceptions, the individual provider's profiles may be analyzed for confirmation.

Sort Sequence

Category of service, provider peer group, provider number

Distribution

Distribution	Media	Copies	Frequency
EDS	CRLD		Quarterly, on request
IFSSA	CRLD		Quarterly, on request

Provider Group Summary Profile

Part II Report Definition Information

Functional Area:	SURS
Report Number:	SUR-0323-Q

Detailed Field Definitions

The report field descriptions for the Provider Group Summary Profile Report are identical to those of the Provider Exception Summary Profile Report. Please refer to the report field descriptions section for Provider Exception Summary Profile Report for this information.

Report Example: Provider Group Summary Profile

```
  REPORT:  SUR-3230- Q                              INDIANAIM
 PROCESS:  DSIBMU31                                                                  PAGE NUM: 99,999
LOCATION:  HUGS323B                  PROVIDER GROUP SUMMARY PROFILE REPORT          RUN DATE: 05/08/99
                                                                                    RUN TIME: 14:37:56
CAT SVC-RPT SEQ 06-A              INDIANA MEDICAID MANAGEMENT INFORMATION SYSTEM

                                                                          PERIOD:  MM YY THRU MM YY
        MEDICAID                      CATEGORY OF SERVICE – 06 - PHYSICIAN

REPORT--LOCATION – IN - INDIANA            TYPE – T31 - Physician              SPEC          - S332 - ENT
SIZE N/A    ORG. TYP    FACILITY TYPE
DETAIL--LOCATION - 46    - LaPorte         TYPE – 031 - Physician              SPEC          - 332  - OTOLOGIST, LARYNGOLOGIST
SIZE 00000  ORG. TYP    FACILITY TYPE     G/I

PROV     -  999999999      SMITH K BEN MD                        1509  STATE STREET  #2A    LAPORTE                IN  45647 G/I G

REFERENCE PERIOD:  MMM YY-MMM YY    FYTD PERIOD -  MMM YY-MMM YY  REFERENCE PERIOD PEER GROUP COUNT -      99,999    TOT WGT -  999,999

PERIOD WEIGHT MULTIPLIERS: 99.9, 99.9, 99.9, 99.9, 99.9

                                  -----TRENDS----- -REFERENCE PERIOD-    MMM YY    MMM YY    MMM YY    MMM YY    MMM YY
----------ACTIVITY SUMMARY----------      PEER    INDIV  WEIGHT PER GP AVG    MMM YY    MMM YY    MMM YY    MMM YY    MMM YY

01-Amount Billed                  X999.99  X999.99  99,999  99,999.99  999999.99  999999.99  999999.99  999999.99  999999.99 X
02-Amount Paid                    X999.99  X999.99  99,999  99,999.99  999999.99  999999.99  999999.99  999999.99  999999.99 X
03-Percent Paid of Billed         X999.99  X999.99  99,999  99,999.99  999999.99  999999.99  999999.99  999999.99  999999.99 X
04-Number of Claims               X999.99  X999.99  99,999  99,999.99  999999.99  999999.99  999999.99  999999.99  999999.99 X
05-Number of Recipients           X999.99  X999.99  99,999  99,999.99  999999.99  999999.99  999999.99  999999.99  999999.99 X
06-Avg Amt Billed/Recipient       X999.99  X999.99  99,999  99,999.99  999999.99  999999.99  999999.99  999999.99  999999.99 X
07-Avg Amt Paid/Recipient         X999.99  X999.99  99,999  99,999.99  999999.99  999999.99  999999.99  999999.99  999999.99 X

TOTAL EXCEPTIONS         999,999                                            99,999     99,999     99,999     99,999     99,999
TOTAL WEIGHT             999,999                                        99,999,999 99,999,999 99,999,999 99,999,999 99,999,999

FYTD TOTALS TITLE XIX     NO SVCS   9999  AMT BILLED 999,999.99    AMT ALLOWED  999,999.99  AMT PAID 999,999.99  PCT PAID/BILLED 999.99
            TITLE XVIII             9999             999,999.99                 999,999.99           999,999.99                  999.99
```

Report Definition: SUR-3240-Q Provider Exception Deselection

Part I Report Definition Information

Functional Area:	SURS
Report Number:	SUR-3240-Q
Job Name:	DSIBMU31
Report Title:	Provider Exception Deselection

Description of Information

The Provider Summary Deselection Listing Report is produced when the user has created a list of providers that are to be eliminated from exception processing. If a provider is deselected, that provider's activity is included in the peer group summaries (325) and a summary profile (321) is produced. However, these providers are not eligible for the exception profiles (320) or the summary exception rank report (330). The deselected provider, deselect date, and comments are input by the user into the Provider/Recipient Deselection Input Window.

Purpose of Report

The Provider Summary Deselection Listing Report provides a reference for the user on providers not included in exception processing.

Sort Sequence

Provider number

Distribution

Distribution	Media	Copies	Frequency
EDS	Hardcopy	One	Quarterly
IFSSA	Hardcopy	One	Quarterly

Provider Exception Deselection

Part II Report Definition Information

Functional Area: SURS

Report Number: SUR-3240-Q

Detailed Field Definitions

Table 6.7 – Field Description

Field	Description
Period	The time frame reflected by the data on the report.
Provider Number	The deselected provider's number (user input on the Deselection File).
Review Date	A user specified date, for informational purposes only, usually identifying the date of previous review. In Indiana, providers are deselected for one year following a review of their practice, then are removed from the deselection listing to allow exception processing rank reporting if aberrant billing practice exists.
Review Status & Comments	The user gives a brief reason for deselection, such as "on review" or under investigation (user input on the Deselection File).
Total Providers Deselected	The total number of providers who are on the deselection file.

Report Example: Provider Exception Deselection

```
  REPORT:  SUR-3240- Q                              INDIANAIM
 PROCESS:  DSIBMU31                                                                                PAGE NUM: 99,999
LOCATION:  HUGS324B                      PROVIDER SUMMARY DESELECTION LISTING                      RUN DATE: 05/08/99
                                                                                                   RUN TIME: 14:37:56
                                                                                           PERIOD:     MM YY THRU MM YY
          PROVIDER NUMBER         REVIEW DATE            REVIEW STATUS AND COMMENTS

            999999999               MMDDCCYY                XX

            999999999               MMDDCCYY                XX

            999999999               MMDDCCYY                XX

            999999999               MMDDCCYY                XX

            999999999               MMDDCCYY                XX


                                         TOTAL PROVIDERS DESELECTED 9,999
```

Report Definition: SUR-3250-Q Provider Peer Group Summary Profile

Part I Report Definition Information

Functional Area:	SURS
Report Number:	SUR-3250-Q
Job Name:	DSIBMU31
Report Title:	Provider Peer Group Summary Profile

Description of Information

The Provider Peer Group Summary Profile Report is a statistical summary by peer group for all user-defined parameters. From the data accumulated on the report, peer group averages are calculated and trends are computed to be compared to the individual's activity.

Purpose of Report

The Provider Peer Group Profile Report can be used to assess the cost and type of medical care provided by each provider peer group. In provider case reviews, the data on this report can be compared to the individual provider's activity to determine if the provider's activity comprised a significant portion of the peer group's total. This report can also be used to measure the effectiveness of, or the need for, major program changes.

This report can be referenced to analyze the medical activity of selected provider types or specialties. Provider activity within any given area of the state can be studied and compared to other areas.

Sort Sequence

Category of service, report sequence, peer group

Distribution

Distribution	Media	Copies	Frequency
EDS	CRLD		Quarterly
IFSSA	CRLD		Quarterly

Provider Peer Group Summary Profile

Part II Report Definition Information

Functional Area: SURS

Report Number: SUR-3250-Q

Detailed Field Definitions

Table 6.8 – Field Description

Field	Description
Cat Svc- Rpt Seq	This field displays the report sequence within category of service when the multiple report sequence option is used.
Period	The time frame reflected by the data on the report.
Category of Service	The peer group's medical care category and description being reported.
Report Location	The peer group location code and description.
Report Type	The peer group type code and description.
Report Spec	The peer group specialty code and description.
Report Size	The peer group bed size when this field is used.
Report Org. Type	The peer group organization type when this field is used.
Report Facility Type	The peer group facility type when this field is used.
Reference Period	The reporting period selected by the user as the period on which peer group averages are to be computed for comparison to the provider's activity for determination of exceptions. P1 is the most recent period.
FYTD Period	The fiscal year-to-date period which defines data to be included in the FYTD totals at the bottom of the report. The user determines the month to be used for the fiscal year-to-date accumulations. The dates displayed in this field begin with the first month of the fiscal year and end with the last month of data being reported.
Ref Period Peer Grp Count	The total number of providers in the peer group who have data in the reference period, and whose activity is used to compute the peer group averages.
Reporting Period Headers	The month(s) and year(s) for beginning and ending dates for reporting periods 1 through 5.
Activity Summary	A list of user-defined report elements that apply to the report image in which the provider has activity. Exception limits established by the user for each parameter appear immediately following the line item to which it pertains. Up to 99 line items can be selected by the user according to current needs. Each Category of Service should have its own set applicable to the type of medical care being provided. Within each Category of Service, nine different sets of line items are available. The ninth set is considered the 'default' activity summary and applies to all providers in the Category of Service whose specialty is not specified elsewhere.

Table 6.8 – Field Description

Field	Description
Number of Provs Reporting	The number of providers who have data for each of the reporting periods.
Number of Different Patients	The number of recipients for each of the reporting periods.
Line Item Number	The line item number as defined on the 40 control file.
Line Item Description	The line item description as defined on the 40 control file.
Trend	A measure of the change in totals over the five reporting periods for the peer group. TREND = $\frac{100 \times (2P1 + P2 - P4 - 2P5)}{2 \times (P1 + P2 + P3 + P4 + P5)}$ P1 represents the most recent reporting period, P2 represents the next most recent reporting period, etc. If less than five periods are reported, the value of unused periods is zero, therefore; the result of the trend calculation may not be valid. The Trends field can be suppressed, if the user determines this information is of little value and/or may be misleading.
Line Item Values [Periods 1-5]	The computed values for individual reporting periods (1-5) for each line item.

Table 6.9 – FYTD Totals (Title XIX and XVIII)

Field	Description
Svcs	Total number of services performed by this peer group for the Title XIX and XVIII payment classes.
Billed	Total dollars billed for services performed by this peer group for the Title XIX and XVIII payment classes.
Allowed	Total dollars allowed for services performed by this peer group for the Title XIX and XVIII payment classes.
Paid	Total dollars paid for services performed by this peer group for the Title XIX and XVIII payment classes.
Pct/Pd/Billed	Percentage of the amount billed that was paid for services in the Title XIX and XVIII payment classes.

Report Example: Provider Peer Group Summary Profile

```
  REPORT:  SUR-3250- Q                              INDIANAIM
 PROCESS:  DSIBMU31                                                                  PAGE NUM: 99,999
LOCATION:  HUGS325B                  PROVIDER PEER GROUP SUMMARY PROFILE REPORT      RUN DATE: 05/08/99
                                                                                    RUN TIME: 14:37:56
CAT SVC-RPT SEQ 06-A               INDIANA MEDICAID MANAGEMENT INFORMATION SYSTEM

                                                                        PERIOD:  MM YY THRU MM YY
                                      CATEGORY OF SERVICE – 06 - PHYSICIAN

REPORT--LOCATION – IN - INDIANA          TYPE – T31 - Physician              SPEC          - S332 - ENT
SIZE N/A    ORG. TYP    FACILITY TYPE

            REFERENCE PERIOD  MMM YY-MMM YY    FYTD PERIOD -  MMM YY-MMM YY  REFERENCE PERIOD PEER GROUP COUNT -      99,999

                                                    MMM YY        MMM YY        MMM YY        MMM YY        MMM YY
----------ACTIVITY SUMMARY----------       TREND     MMM YY        MMM YY        MMM YY        MMM YY        MMM YY

NUMBER OF PROVIDERS REPORTING                      9,999.99      9,999.99      9,999.99      9,999.99      9,999.99
NUMBER OF DIFFERENT PATIENTS                       9,999.99      9,999.99      9,999.99      9,999.99      9,999.99

  01-Amount Billed                  - 999.99    9,999,999.99  9,999,999.99  9,999,999.99  9,999,999.99  9,999,999.99
  02-Amount Paid                    - 999.99    9,999,999.99  9,999,999.99  9,999,999.99  9,999,999.99  9,999,999.99
  03-Percent Paid of Billed         - 999.99    9,999,999.99  9,999,999.99  9,999,999.99  9,999,999.99  9,999,999.99
  04-Number of Claims               - 999.99    9,999,999.99  9,999,999.99  9,999,999.99  9,999,999.99  9,999,999.99
  05-Number of Recipients           + 999.99    9,999,999.99  9,999,999.99  9,999,999.99  9,999,999.99  9,999,999.99
  06-Avg Amt Billed/Recipient       + 999.99    9,999,999.99  9,999,999.99  9,999,999.99  9,999,999.99  9,999,999.99
  07-Avg Amt Paid/Recipient         + 999.99    9,999,999.99  9,999,999.99  9,999,999.99  9,999,999.99  9,999,999.99


FYTD TOTALS TITLE XIX        SVCS   9999      BILLED 999,999.99        ALLOWED  999,999.99      PAID 999,999.99  PCT/PAID/BILLED 999.99
            TITLE XVIII             9999             999,999.99                 999,999.99           999,999.99                  999.99
```

Report Definition: SUR-3260-Q Provider Summary Profile Exception Statistics

Part I Report Definition Information

Functional Area:	SURS
Report Number:	SUR-3260-Q
Job Name:	DSIBMU31
Report Title:	Provider Summary Profile Exception Statistics

Description of Information

The Provider Summary Profile Exceptions Statistics Report displays the statistical information related to each line item on the summary profiles. Three report pages of information are produced for each peer group.

Purpose of Report

With the data from the Provider Summary Profile Exception Statistics Report, the user can analyze each line item for effectiveness and determine if the exception limits are too high or too low. The user can determine the appropriateness of line items and exception limits by analyzing the number and percentage of exception providers for each line.

Ideally, the user wants approximately only the top 5% of providers in a peer group to except on a line. This percentage may vary depending on the size of the peer group, the nature of the line item, and several other factors. Before the exception limits on any line are adjusted, the user should appraise all peer group averages reported in the reporting image, the standard deviations of each, the number of providers in each, and the intended use of the information from the line item.

If a certain line item consistently has no exceptions across all peer groups, the user should evaluate the need for the line item, and replace it with one more likely to reveal aberrant activity.

Sort Sequence

Category of service, report sequence, peer group

Distribution

Distribution	Media	Copies	Frequency
EDS	CRLD		Quarterly
IFSSA	CRLD		Quarterly

Provider Summary Profile Exception Statistics

Part II Report Definition Information

Functional Area: SURS

Report Number: SUR-3260-Q

Detailed Field Definitions

Table 6.10 – Field Description

Field	Description
Cat Svc - Rpt Seq	This field displays the report sequence within the category of service when the multiple report sequence option is used.
Period	The time frame reflected by the data on the report.
Report Location	The peer group location code and description.
Report Type	The peer group type code and description.
Report Spec	The peer group specialty code and description.
Report Size	The peer group bed size. Not currently in use.
Report Org. Type	The peer group organization type when this field is used.
Report Facility Type	The peer group facility type when this field is used.
Reference Period	The reporting period selected by the user as the period on which peer group averages are to be computed.
Reference Period Peer Group Count	The total number of providers in the peer group who have activity in the reference period.
Number of Provs Reporting	The total number of providers who had activity in each of the reporting periods.
Activity Summary	A list of user-defined report elements which apply to the report image being reported.
Line Item Number	The line item number as defined on the 40 control file.
Line Item Description	The line item description as defined on the 40 control file.
Reference Period Average	The peer group average for each line item based on the reference period activity.
Reference Period Low Limit	The value of the low limit established by the user. If the limit is a percentage or standard deviation variance, the minimum allowable calculated from the peer group average appears in this field.
Reference Period High Limit	The value of the high limit established by the user. If the limit is a percentage or standard deviation variance, the maximum allowable value calculated from the peer group average appears in this field.
Exception % of Peer Group	The number of providers excepting on the line expressed as a percentage of all providers in the peer group.

Table 6.10 – Field Description

Field	Description
Average	The average value for the peer group for the line item.
Std Dev	The value of one standard deviation for the peer group. Asterisks indicate there is not more than one provider with activity for the line.
Max Value	The highest value that occurred for any individual within the peer group during the reference period.
Exceptions % of Per Gp	The percent of providers in the peer group who excepted on the line during the reference period.
All Periods-Total Exceptions	The total number of exceptions for the line during all period reported.
Reference Period Percentiles	The value of the line item occurring at each of six user-defined percentiles. **5, 25, 50, 75. 90, 98**

Report Example: Provider Summary Exception Statistics (1 of 3)

```
  REPORT:  SUR-3260- Q                                   INDIANAIM
 PROCESS:  DSIBMU31                                                                    PAGE NUM: 99,999
LOCATION:  HUGS325B                PROVIDER SUMMARY PROFILE EXPCEPTIONS STATISTICS REPORT   RUN DATE: 05/08/99
                                                                                         RUN TIME: 14:37:56
CAT SVC-RPT SEQ 06-A                  INDIANA MEDICAID MANAGEMENT INFORMATION SYSTEM

                                                                          PERIOD:   MM YY THRU MM YY
                                          CATEGORY OF SERVICE – 06 - PHYSICIAN

REPORT--LOCATION – IN - INDIANA              TYPE – T31 - Physician          SPEC          - S332 - ENT
SIZE N/A    ORG. TYP    FACILITY TYPE

            REFERENCE PERIOD  MMM YY-MMM YY                        REFERENCE PERIOD PEER GROUP COUNT -      99,999

                                  ---------REFERENCE PERIOD--------- ------------EXCEPTION COUNTS FOR PERIOD ENDING-------------
                                            ----LOW---- ----HIGH---     MMM YY     MMM YY     MMM YY     MMM YY     MMM YY
----------ACTIVITY SUMMARY---------- --AVERAGE-    LIMIT       LIMIT       LO    HI    LO    HI    LO    HI    LO    HI    LO    HI


NUMBER OF PROVIDERS REPORTING                                          9,999,999   9,999,999   9,999,999   9,999,999   9,999,999

  01-Amount Billed                    99999.99       +0.00        0.00     0     0      0     0    0     0      0     0     0      0
  02-Amount Paid                      99999.99       +0.00        0.00     0     0      0     0    0     0      0     0     0      0
  03-Percent Paid of Billed           99999.99       +0.00        0.00     0     0      0     0    0     0      0     0     0      0
  04-Number of Claims                 99999.99       +0.00        0.00     0     0      0     0    0     0      0     0     0      0
  05-Number of Recipients             99999.99       +0.00        0.00     0     0      0     0    0     0      0     0     0      0
  06-Avg Amt Billed/Recipient         99999.99       +0.00        0.00     0     0      0     0    0     0      0     0     0      0
  07-Avg Amt Paid/Recipient           99999.99       +0.00        0.00     0     0      0     0    0     0      0     0     0      0
```

Report Example: Provider Summary Exception Statistics (2 of 3)

```
  REPORT:  SUR-3260- Q                                   INDIANAIM
 PROCESS:  DSIBMU31                                                                  PAGE NUM: 99,999
LOCATION:  HUGS325B                PROVIDER SUMMARY PROFILE EXPCEPTIONS STATISTICS REPORT            RUN DATE: 05/08/99
                                                                                    RUN TIME: 14:37:56
CAT SVC-RPT SEQ 01-A                  INDIANA MEDICAID MANAGEMENT INFORMATION SYSTEM

                                                                    - GROUP   PERIOD:   MM YY THRU MM YY
                                          CATEGORY OF SERVICE – 06 - PHYSICIAN

REPORT--LOCATION – IN - INDIANA              TYPE – T31 - Physician          SPEC          - S332 - ENT
SIZE N/A    ORG. TYP    FACILITY TYPE

            REFERENCE PERIOD  MMM YY-MMM YY                    REFERENCE PERIOD PEER GROUP COUNT -      99,999


                                    ------------------------REFERENCE  PERIOD-----------------------     -ALL PERIODS-

----------ACTIVITY SUMMARY----------       --AVERAGE-     --STD DEV--         --MAX VALUE-     --EXCEPTIONS-      ----TOTAL---
                                                                                 % OF PER GRP      -EXCEPTIONS-
  01-Amount Billed                         99999.99       999999.99           999999.99          999.99             99999
  02-Amount Paid                           99999.99       999999.99           999999.99          999.99             99999
  03-Percent Paid of Billed                99999.99       999999.99           999999.99          999.99             99999
  04-Number of Claims                      99999.99       999999.99           999999.99          999.99             99999
  05-Number of Recipients                  99999.99       999999.99           999999.99          999.99             99999
  06-Avg Amt Billed/Recipient              99999.99       999999.99           999999.99          999.99             99999
  07-Avg Amt Paid/Recipient                99999.99       999999.99           999999.99          999.99             99999
```

Report Example: Provider Summary Exception Statistics (3 of 3)

```
  REPORT:  SUR-3260- Q                                  INDIANAIM
 PROCESS:  DSIBMU31                                                                  PAGE NUM: 99,999
LOCATION:  HUGS325B                PROVIDER SUMMARY PROFILE EXPCEPTIONS STATISTICS REPORT            RUN DATE: 05/08/99
                                                                                    RUN TIME: 14:37:56
CAT SVC-RPT SEQ 01-A                  INDIANA MEDICAID MANAGEMENT INFORMATION SYSTEM

                                                                    - GROUP   PERIOD:   MM YY THRU MM YY
                                          CATEGORY OF SERVICE – 06 - PHYSICIAN

REPORT--LOCATION – IN - INDIANA              TYPE – T31 - Physician          SPEC          - S332 - ENT
SIZE N/A    ORG. TYP    FACILITY TYPE

            REFERENCE PERIOD  MMM YY-MMM YY                          REFERENCE PERIOD PEER GROUP COUNT -      99,999


-----------ACTIVITY SUMMARY----------        ----------------------REFERENCE PERIOD PERCENTILES----------------------

                                                 99.9         99.9         99.9         99.9         99.9         99.9
  01-Amount Billed                            99999.99     999999.99    999999.99       999.99    999999.99    999999.99
  02-Amount Paid                              99999.99     999999.99    999999.99       999.99    999999.99    999999.99
  03-Percent Paid of Billed                   99999.99     999999.99    999999.99       999.99    999999.99    999999.99
  04-Number of Claims                         99999.99     999999.99    999999.99       999.99    999999.99    999999.99
  05-Number of Recipients                     99999.99     999999.99    999999.99       999.99    999999.99    999999.99
  06-Avg Amt Billed/Recipient                 99999.99     999999.99    999999.99       999.99    999999.99    999999.99
  07-Avg Amt Paid/Recipient                   99999.99     999999.99    999999.99       999.99    999999.99    999999.99
```

Report Definition: SUR-3270-Q Provider Summary Profile (Forced)

Part I Report Definition Information

Functional Area:	SURS
Report Number:	SUR-3270-Q
Job Name:	DSIBMU31
Report Title:	Provider Summary Profile (Forced) Report

Description of Information

The Provider Summary Profile (Forced) Report provides the user with a report that is identical in format to the Provider Summary Profile (320) report. It contains a summary profile for any provider who has excepted on a line item which the user designates as a forced exception line item. The exception limit should be defined carefully in the 40 Control File in order to produce the report on only the most deviant providers; otherwise, the volume of paper produced could be unmanageable.

Purpose of Report

The user can request a Provider Summary Profile (Forced) Report to support areas of special study.

Sort Sequence

Category of service, provider peer group, provider number

Distribution

Distribution	Media	Copies	Frequency
EDS	CRLD		Quarterly, on request
IFSSA	CRLD		Quarterly, on request

Provider Summary Profile (Forced)

Part II Report Definition Information

Functional Area:	SURS
Report Number:	SUR-3270-Q

Detailed Field Definitions

The report field descriptions for the Provider Summary Profile (Forced) Report are identical to those of the Provider Exception Summary Profile Report. Please refer to the report field descriptions section for Provider Exception Summary Profile Report for this information.

Report Example: Provider Summary Profile (Forced) Exception

```
REPORT:  SUR-3270- Q                              INDIANAIM
 PROCESS:  DSIBMU31                                                                  PAGE NUM: 99,999
LOCATION:  HUGS323B                  PROVIDER SUMMARY PROFILE REPORT (FORCED)       RUN DATE: 05/08/99
                                                                                    RUN TIME: 14:37:56
CAT SVC-RPT SEQ 06-A              INDIANA MEDICAID MANAGEMENT INFORMATION SYSTEM

                                                                          PERIOD:  MM YY THRU MM YY
        MEDICAID                      CATEGORY OF SERVICE – 06 - PHYSICIAN

REPORT--LOCATION – IN - INDIANA            TYPE – T31 - Physician              SPEC          - S332 - ENT
SIZE N/A    ORG. TYP    FACILITY TYPE
DETAIL--LOCATION - 46    - LaPorte         TYPE – 031 - Physician              SPEC          - 332  - OTOLOGIST, LARYNGOLOGIST
SIZE 00000  ORG. TYP    FACILITY TYPE

PROV     -  999999999      SMITH K BEN MD                        1509  STATE STREET  #2A    LAPORTE                IN  45647 G/I G

REFERENCE PERIOD:  MMM YY-MMM YY    FYTD PERIOD -  MMM YY-MMM YY  REFERENCE PERIOD PEER GROUP COUNT -      99,999    TOT WGT -  999,999

PERIOD WEIGHT MULTIPLIERS: 99.9, 99.9, 99.9, 99.9, 99.9

                                  -----TRENDS----- -REFERENCE PERIOD-    MMM YY    MMM YY    MMM YY    MMM YY    MMM YY
----------ACTIVITY SUMMARY----------      PEER    INDIV  WEIGHT PER GP AVG    MMM YY    MMM YY    MMM YY    MMM YY    MMM YY

01-Amount Billed                       X999.99  X999.99  99,999  99,999.99  999999.99  999999.99  999999.99  999999.99  999999.99 X
02-Amount Paid                         X999.99  X999.99  99,999  99,999.99  999999.99  999999.99  999999.99  999999.99  999999.99 X
03-Percent Paid of Billed              X999.99  X999.99  99,999  99,999.99  999999.99  999999.99  999999.99  999999.99  999999.99 X
04-Number of Claims                    X999.99  X999.99  99,999  99,999.99  999999.99  999999.99  999999.99  999999.99  999999.99 X
05-Number of Recipients                X999.99  X999.99  99,999  99,999.99  999999.99  999999.99  999999.99  999999.99  999999.99 X
06-Avg Amt Billed/Recipient            X999.99  X999.99  99,999  99,999.99  999999.99  999999.99  999999.99  999999.99  999999.99 X
07-Avg Amt Paid/Recipient              X999.99  X999.99  99,999  99,999.99  999999.99  999999.99  999999.99  999999.99  999999.99 X

TOTAL EXCEPTIONS         999,999                                                 99,999     99,999     99,999     99,999     99,999
TOTAL WEIGHT             999,999                                              99,999,999 99,999,999 99,999,999 99,999,999 99,999,999

FYTD TOTALS TITLE XIX     NO SVCS   9999  AMT BILLED 999,999.99    AMT ALLOWED  999,999.99  AMT PAID 999,999.99  PCT PAID/BILLED 999.99
            TITLE XVIII             9999             999,999.99                 999,999.99           999,999.99                  999.99
```

Report Definition: SUR-3300-Q Provider Summary Profile Exception Ranking

Part I Report Definition Information

Functional Area:	SURS
Report Number:	SUR-3300-Q
Job Name:	DSIBMU31
Report Title:	Provider Summary Profile Exception Ranking

Description of Information

The Provider Summary Profile Exception Ranking Report lists the exception providers in descending weight order. The weight is an accumulation of the weight assigned to each exception item the provider has on his summary profile. In addition to basic information about the provider, the ranking report gives a volume summary of the provider's activity during the reference period in order to aid the reviewer in selecting providers for initial review. A separate ranking report is generated for each category of service.

By using minimum activity parameters (recipients, services, claims, and charges), the user can eliminate low volume providers from ranking since utilization review of low volume providers may not be cost effective. In most cases, these exceptions are unjustifiably created because of the provider's limited activity. The minimums established apply to all categories of service.

Purpose of Report

The Provider Summary Profile Exception Ranking Report is the first report used in selecting providers for review. Once a provider is selected from the ranking report, that provider's summary profile is reviewed to determine if further investigation is appropriate.

Sort Sequence

Category of service, exception weight

Distribution

Distribution	Media	Copies	Frequency
EDS	CRLD		Quarterly
IFSSA	CRLD		Quarterly

Provider Summary Profile Exception Ranking

Part II Report Definition Information

Functional Area: SURS

Report Number: SUR-3300-Q

Detailed Field Definitions

Table 6.11 – Field Description

Field	Description
Category of Service	The provider medical care category and description being reported.
Report Sequence	This field displays the report sequence within category of service when the multiple report sequence option is used.
Reference Period	The reporting period selected by the user as the period on which peer group averages are to be computed for comparison to the provider's activity for determination of exceptions. P1 is the most recent period.
Period Weight Multipliers	A factor selected by the user by which the computed exception weight is multiplied for each corresponding reporting period. This enables the user to effect higher weight on exception items in a selected reporting period such as the reference period, and lower weight in periods where the data may not be as complete due to the claim filing deadline. This factor is a whole number and one decimal place. There are five period weight multipliers.
Reporting Limit	The maximum number of providers to be ranked as specified by the user. Default value is 1000.Currently **500**.
Minimums for Exception Reporting [Recipients, Services, Claims, Charges	User selected activity minimums that must be met before a provider is considered an exception provider. Minimum values for number of dollars billed, recipients, claims, and services can be established by the user to ensure that low volume providers are not considered exceptions. Low volume providers receive high exception weight because their averages, percentages, and services per recipient are distorted simply because they perform very few services. By setting these minimums at realistic levels, the exception reports produced are more likely to represent valid cases of abuse or misutilization. The values set apply to the provider's activity during the reference period. One set of minimums is used for all categories of service.
Rank	The relative rank of the provider among all providers reported. (Rank of 1 is assigned to the provider with the highest weight whose activity volume is equal to or greater than the minimums).
Totl Weight	The exception weight from the provider's summary profile which determines rank. Providers can be ranked by their exception weight from any one of the reporting periods or by total weight of all periods. The weight source is displayed in the report header. 'TOTL' means the total weight from all reporting periods is used for ranking. 'Per 1' means the exception weight from the most current reporting period is used.

Table 6.11 – Field Description

Field	Description
Tot Exp	The total number of exceptions the provider has for all reporting periods.
Prov	The provider's medical identification number.
Name	The provider's name - last, first, and middle initial.
Loc	The provider's peer group locality code.
Typ	The provider's peer group type code.
Spc	The provider's peer group specialty code.

Table 6.12 – Reference Reporting Period Amounts

Field	Description
Svcs	The total number of services during the reference period based on either dates of service or date of payment.
Billed	The total dollar amount billed by the provider during the reference period based on either dates of service or date of payment.
Allowed	The total dollar amount allowed during the reference period based on either dates of service or date of payment.
Paid	The total dollar amount paid to the provider during the reference period based on either dates of service or date of payment.
No Recips	The total number of recipients the provider performed services for during the reference period based on either dates of service or date of payment.
No Claims	The total number of claims submitted by the provider during the reference period based on either dates of service or date of payment.
SUR-320 Page No	The page number of the exception profile (320) for this provider.

Report Example: Provider Summary Profile Exception Ranking

```
  REPORT:  SUR-3300- Q                              INDIANAIM                                        PAGE NUM: 99,999
 PROCESS:  DSIBMU31                                                                                 RUN DATE: 05/08/99
LOCATION:  HUGS330B            GROUP PROVIDER SUMMARY PROFILE EXCEPTION RANKING REPORT              RUN TIME: 14:37:56

                                        CATEGORY OF SERVICE – 03 - OUTPATIENT

                    REFERENCE PERIOD -  MMM YY-MMM YY      PERIOD WEIGHT MULTIPLIERS:  99.9, 99.9, 99.9, 99.9, 99.9

REPORTING LIMIT - 99999    MINIMUM RECIPIENTS -    99999    MINIMUM SERVICES - 99999    MINIMUM CLAIMS - 99999  MINIMUM CHARGES - 99999

                                                                 -----------------REFERENCE REPORTING PERIOD------------------
       TOTL   TOT ----------------PROVIDER-------------------------        -------------AMOUNTS-----------     NO.    NO.  SUR-320
RANK  WEIGHT  EXP   PROV         NAME                    LOC  TYP  SPC   SVCS     BILLED    ALLOWED       PAID   RECIPS  CLMS  PAGE NO

  1      4853  32  999999999    ST ANTHONY MED CENTER   IN   TO1  S010  4853   999999.99  999999.99   99999.99     668    973     14

  2      2482  18  999999999    TIPTON COUNTY MEMORIAL  IN   TO1  S010  2508   999999.99  999999.99   99999.99     269    473     12

  3      2432  13  999999999    LIFELINES CHILDRENS     IN   TO1  S012   119   999999.99  999999.99   99999.99      15     73      1

  4      2167   9  999999999    GOSHEN GENERAL          IN   TO1  S010  5994   999999.99  999999.99   99999.99     600     97     13

  5      2085  10  999999999    AMERICAN EYE INS        IN   TO2  S020     6   999999.99  999999.99   99999.99       5      3      3
```

Window Definition: Provider Select

Introduction

The Provider Select Window presents the user with a listing of provider history/random sample requests tabled for display on the Claims Listing Window, or waiting to be processed.

The Provider Select Window is used to gain access to the following functions:

- View a listing of tabled requests
- Change an unprocessed request
- Delete a claim listing from the table
- Access the SUR Provider History/Sample Request Window
- Access the Statistical Summary for Sample Request Window
- Access the SUR Claim Listing Window

The Provider Select Window will be accessed utilizing the mouse by clicking the Provider History/Sample Button on the SUR Main Menu. The window may be accessed from the SUR Main Menu using the keyboard, by pressing the letter **H.**

Field Information

Field Name: PROVIDER NUMBER

Description – Provider's Medicaid ID number for which the request was logged on the SUR Provider History/Sample Request Window

Format – Nine digit, numeric

Features – Display only

Edits – None

To correct – N/A

Field Name: REQUEST DATE

Description – The date the request was logged on the SUR Provider History/Sample Request Window

Format – CCYYMMDD

Features – Display only

Edits – None

To correct – N/A

Field Name: REQUEST TIME

Description – The time the request was logged on the SUR Provider History/Sample Request Window

Format – HH:MM:SS

Features – Display only

Edits – None

To correct – N/A

Field Name: RQST BY

Description – The ID of the user who requested the history/sample

Format – Four character alphanumeric

Features – Display only

Edits – None

To correct – N/A

Field Name: PURGE DATE

Description – Seven calendar days from the original request date, or seven calendar days from the last STORE logged for the claim listing

Format – CCYYMMDD

Features – Display only

Edits – None

To correct – N/A

Field Name: SRT OPT (1-5)

Description – The sort options applied to the request

Format – Valid Values

B. Admit Date

C. Age

D. Attending Physician

E. Category of Service

F. Claim Charge

G. Claim Paid

H. Detail Charge

I. Detail Allowed

J. Diagnosis Code

K. Dispense Date

L. Date of Payment

M. Date of Service

N. DRG

O. Drug Class

P. Drug Code

Q. EOB

R. ICN

S. Lock-In Indicator

T. Nursing Home Indicator

U. Prescribing Physician

V. Procedure Modifier

W. Recipient Name

X. Referring Physician

Y. Revenue Code

Z. RID

Features – Display only

Edits – None

To correct – N/A

Field Name: DAT TYP

Description – The date type used for the request

Format – DOP = remittance date

DOS = service date

Features – Display only

Edits – None

To correct – N/A

Field Name: HISTORY DATES FROM

Description – The low date in a range of dates specified for the request

Format – CCYYMMDD

Features – Display only

Edits – None

To correct – N/A

Field Name: HISTORY DATES TO

Description – The high date in a range of dates specified for the request

Format – CCYYMMDD

Features – Display only

Edits – None

To correct – N/A

Field Name: RND SEL

Description – The random percentage type used for generation of the request; percent of claims or percent of recipients

Format – C or R

Features – Display only

Edits – None

To correct – N/A

Field Name: PCT RND

Description – Sample percentage requested

Format – Three character numeric

Features – Display only

Edits – None

To correct – N/A

Other Messages

"You have to select a row" – Inquire and Change buttons

"Save successful" – Save button

"Save unsuccessful" – Save button

"Do you really want to delete this record?" – Delete button

"Delete successful" – Delete button

"Delete unsuccessful" – Delete button

"Continue without saving?" – Exit button

Window Example: Provider Select

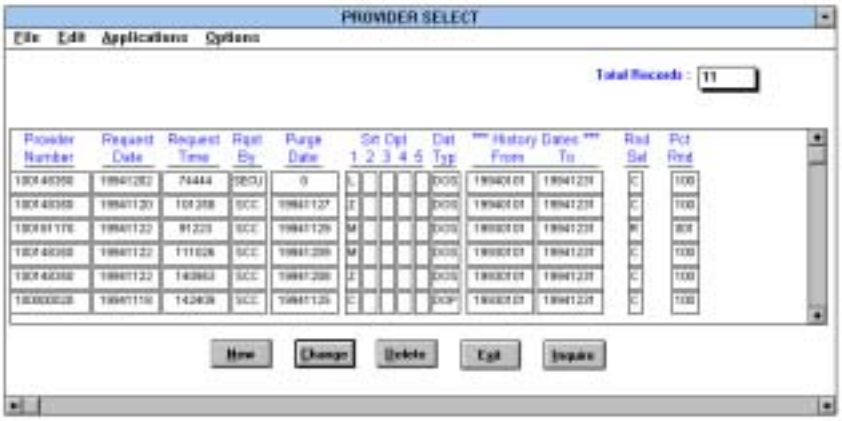


Figure 2 – Provider Select Window

Window Definition: SUR Provider History/Sample Request

Introduction

The Surveillance and Utilization Review Provider History/Sample Request Window provides the user with the capability to create a representation of the provider's overall practice by displaying a percentage (selected by the user) of randomly generated claim examples (a sample percentage of 100% would generate a total history). The accompanying Statistical Summary for History/Sample Request Window is intended to assist the user in deciding on the appropriate percentage, based on the statistical universe, to produce a statistically valid random sample. Frequently, a provider's misutilization involves only two or three areas; numerous select and sort options can be used to focus on only those areas identified as problems.

Logged requests will be processed for display on the SUR Claim Listing Window.

The SUR Provider History/Sample Request Window is used to gain access to the following functions:

Request a provider history or random sample claim listing.

Access the Statistical Summary for Sample Request Window for the provider displayed.

Access the SUR Claim Listing Window for the corresponding processed request.

Access the Selection Criteria Inquiry Window for the corresponding request.

The SUR Provider History/Sample Request Window will be accessed utilizing the mouse by clicking the NEW or CHANGE button on the Provider Select Window. The window may be accessed from the Provider Select Window using the keyboard, by pressing the Alt key simultaneously with the letter N. The SUR Provider History/Sample Request Window may also be accessed, for previously logged requests, by highlighting the desired request and clicking Inquire, or selecting Inquire for the Options menu.

Field Information

Field Name: PROVIDER NUMBER

Description – Provider's Medicaid ID number

Format – Nine character, numeric

Features – None

Edits – 80031 - Provider Not Found

To correct – Verify and key valid 9 digit provider number

Field Name: PROVIDER NAME

Description – Provider's name in Last, First format

Format – Alpha/numeric (Last, First, M.I.)

Features – System generated

Edits – None

To correct – N/A

Field Name: PRIMARY SPECIALTY

Description – The specialty designated as primary by the provider as carried on the Provider Table

Format – Three character numeric

Features – System generated

Edits – None

To correct – N/A

Field Name: TYPE

Description – The provider type as carried on the Provider Table

Format – Two character numeric

Features – System generated

Edits – None

To correct – N/A

Field Name: ADDRESS

Description – The physical address of the provider number designated as primary by the provider, as carried on the Provider Table

Format – Street, city, 2 character alpha state code, 7 character numeric zip code

Features – System generated

Edits – None

To correct – N/A

Field Name: OPERATOR ID

Description – The clerk identification code of the user requesting information

Format – Four character alphanumeric

Features – None

Edits – Data Window Error - Value required for this item

To correct – Key an Operator ID

Field Name: REQUEST DATE

Description – The current date

Format – CCYY/MM/DD

Features – System generated on access

Edits – None

To correct – N/A

Field Name: REQUEST TIME

Description – The current time

Format – HH:MM:SS

Features – System generated on access

Edits – None

To correct – N/A

Field Name: DATE RANGE (type)

Description – The date type to be used for sample generation

Format – Date of service

Paid Date

Features – Drop down list box

Edits – Data Window Error

To correct – Select a Date Range type

Field Name: DATE RANGE (from)

Description – The low date in a range of dates to be used for report generation

Format – CCYYMMDD

Features – None

Edits – 91040 - Invalid Date - must be CCYYMMDD!

To correct – Enter valid date in CCYYMMDD format

Field Name: DATE RANGE (to)

Description – The high date in a range of dates to be used for report generation

Format – CCYYMMDD

Features – None

Edits – 91040 - Invalid Date - must be CCYYMMDD!

To correct – Enter valid date in CCYYMMDD format

Field Name: SORT ORDER (1-5)

Description – Click the Sort Order button to display a drop down list box containing sort value options for sample generation. Click on the value to populate field with option tag name.

Format – Valid Values:

Admit Date

Age

Attending Physician

Category of Service

Claim Charge

Claim Paid

Detail Charge

Detail Allowed

Diagnosis Code

Dispense Date

DOP

DOS

DRG

Drug Class

Drug Code

EOB

ICN

Lock-In Indicator

Nursing Home Code

Prescribing Physician

Procedure/Modifier Code

Recipient Name

Referring Physician

Revenue Code

RID

Features – Clicking on listed value will populate the Sort Order field with the option tag name

Edits – None

To correct – N/A

Field Name: % CLAIMS

Description – Sample percentage requested, based on claim volume

Format – Three character numeric; fractions of a percentage may be requested in the format 9.9, with the decimal as the second digit of the three byte field.

Features – Either % CLAIMS or % RECIPIENTS is required for sample generation

Edits – 91098 - Must be Numeric

To correct – Enter a numeric percentage value

91006 - Field is Required

To correct – Enter either a % claims or % recipients

Field Name: % RECIPIENTS

Description – Sample percentage requested, based on recipient volume

Format – Three character numeric; fractions of a percentage may be requested in the format 9.9, with the decimal as the second digit of the three byte field.

Features – Either % CLAIMS or % RECIPIENTS is required for sample generation

Edits – 91098 - Must be Numeric

To correct – Enter a numeric percentage value

91006 - Field is Required

To correct – Enter either a % claims or % recipients

Field Name: SELECT (option)

Description – Click the Select button to display a drop down list box containing select values available for active claim types. Click on value to populate Select field with option tag name. The Selection Criteria Window will be automatically displayed for value entry. Up to 5 select options may be used for sample generation.

Format – Valid Values:

Admit Date

Age

Attending Physician

Category of Service

Claim Charge

Claim Paid

Detail Charge

Detail Allowed

Diagnosis Code

Dispense Date

DOP

DOS

DRG

Drug Class

Drug Code

EOB

ICN

Lock-in Indicator

Nursing Home Code

Prescribing Physician

Procedure/Modifier Code

Referring Physician

Revenue Code

RID

Features – Click on listed value will populate the Select (option) field with the option tag name

Edits – None

To correct – N/A

Other messages / edits

"Save successful" – Save button

"Save unsuccessful" – Save button

"Continue without saving?" – Exit button

Window Example: SURS Provider History / Sample Request

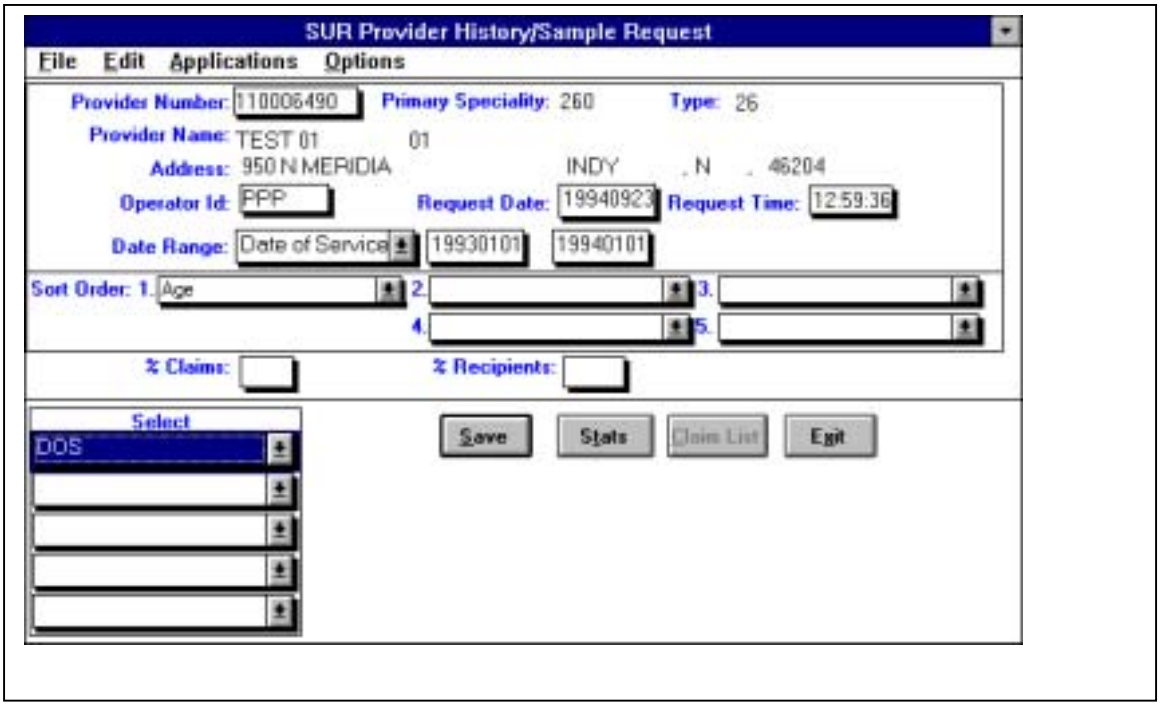


Figure 3 – SUR Provider History/Sample Request Window

Window Definition: Selection Criteria

Introduction

The Selection Criteria Window is a pop up window consequent to Select Criteria tag name specification on the SUR Provider History/Sample Request Window. The Selection Criteria pop up Window is used to specify sample selection criteria values for the selection criteria tag specified on the SUR Provider History/Sample Request Window.

Detailed Field Information

Field Name: (Select value) FROM

Description: The low value in a range of values to be selected for the select option tag name displayed. Up to 8 "From" values may be defined per option tag. Clicking the New Button will allow entry of more than one value for the tag.

***Format* – Option Tag Name**	**Value Format**
Admit Date	CCYYMMDD
Age	999
Attending Physician	999999999X
Category of Service	99
Claim Paid	9999999.99
Detail Charge	9999999.99
Detail Paid	9999999.99
Diagnosis Code	X9999
Dispense Date	CCYYMMDD
DOP	CCYYMMDD
DOS	CCYYMMDD
DRG	999
Drug Class	9999
Drug Code	99999999999
EOB	999
Option Tag Name	Value Format
ICN	9999999999999
Lock-in Indicator	Y or N
Nursing Home Code	Y or N
Prescribing Physician	999999999X

***Format* – Option Tag Name**	**Value Format**
Procedure/Modifier Code	XXXXXXXXXXXX XXXXXXX
Referring Physician	999999999X
Revenue Code	999
RID	999999999999

Features – None

Edits – Editing depends on select option chosen

To correct – Key a valid 'FROM value' format for the select option chosen

Field Name: (Select value) THRU

Description – The high value in a range of values to be selected for the select option displayed. Up to 8 "Thru" values may be defined per option tag. A Thru value must be selected if a From value is keyed.

***Format* – Option Tag Name**	**Value Format**
Admit Date	CCYYMMDD
Age	999
Attending Physician	999999999X
Category of Service	99
Claim Paid	9999999.99
Detail Charge	9999999.99
Detail Paid	9999999.99
Diagnosis Code	X9999
Dispense Date	CCYYMMDD
DOP	CCYYMMDD
DOS	CCYYMMDD
DRG	999
Drug Class	9999
Drug Code	99999999999
EOB	999
ICN	9999999999999
Option Tag Name	Value Format
Lock-in Indicator	Y or N
Nursing Home Code	Y or N
Prescribing Physician	999999999X
Procedure/Modifier Code	XXXXXXXXXXXX XXXXXXX

***Format* – Option Tag Name**	**Value Format**
Referring Physician	999999999X
Revenue Code	999
RID	999999999999

Features – None

Edits – Editing depends on select option chosen

To correct – Key a valid 'THRU value' format for the select option chosen

Other messages / edits

"Save successful" – Save button

"Save unsuccessful" – Save button

"Do you really want to delete this record?" – Delete button

"Delete successful" – Delete button

"Delete unsuccessful" – Delete button

"Continue without saving?" – Exit button

Window Example: Selection Criteria

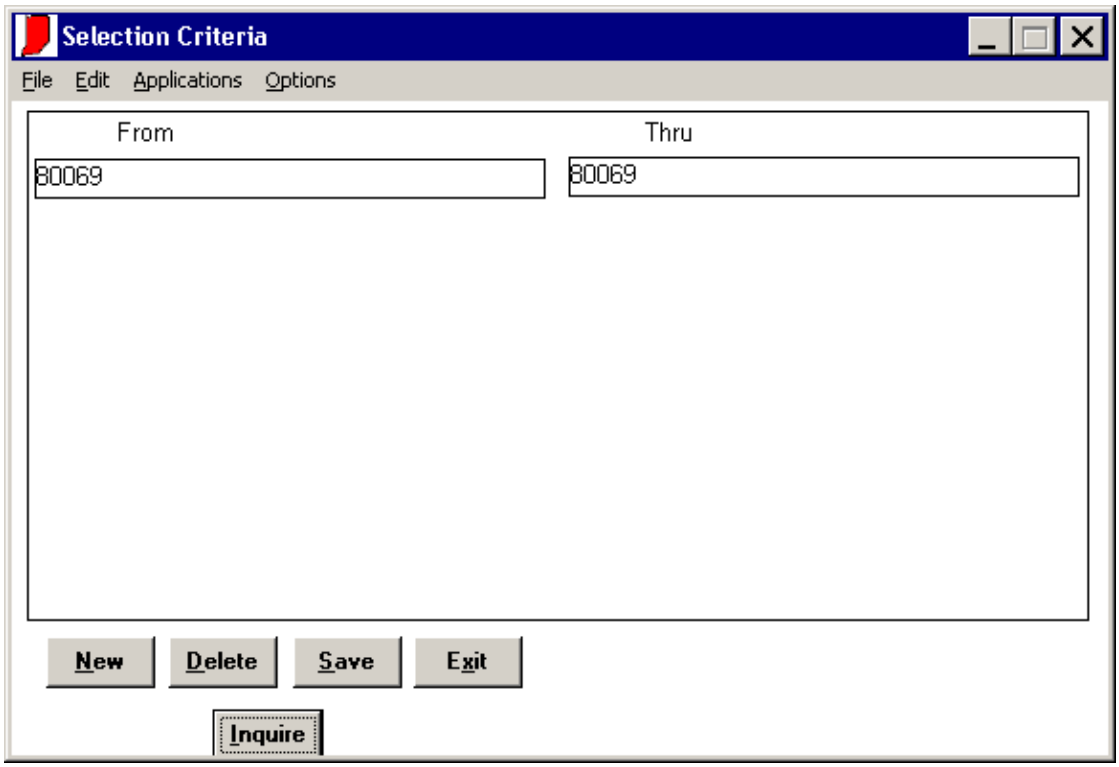


Figure 4 – Selection Criteria Window

Window Definition: Select Criteria Inquiry

Introduction

The Select Criteria Inquiry Window displays all selection criteria with corresponding values that have been logged for the request.

The Select Criteria Inquiry Window will be accessed utilizing the mouse by clicking the Inquire button on the Selection Criteria pop-up Window. Keyboard access is available by pressing the Alt key simultaneously with the I.

Detailed Field Information

Field Name: PROV

Description – Provider number requested for history/sample

Format – Nine character, numeric

Features – System generated

Edits – None

To correct – N/A

Field Name: DATE

Description – The date of the request

Format – CCYYMMDD

Features – System generated

Edits – None

To correct – N/A

Field Name: TIME

Description – The time of the request

Format – HHMMSS

Features – System generated

Edits – None

To correct – N/A

Field Name: SELECT TYPE

Description – A selection type code assigned by the system which corresponds to the selection type entered

Format – One character, alpha

Features – System generated

Edits – None

To correct – N/A

Field Name: RNG LOW

Description – The low value in a range of values entered for the selection type

Format – Dependent upon select type

Features – System generated

Edits – None

To correct – N/A

Field Name: RNG HI

Description – The high value in a range of values entered for the selection type

Format – Dependent upon select type

Features – System generated

Edits – None

To correct – N/A

Window Example: Select Criteria Inquiry

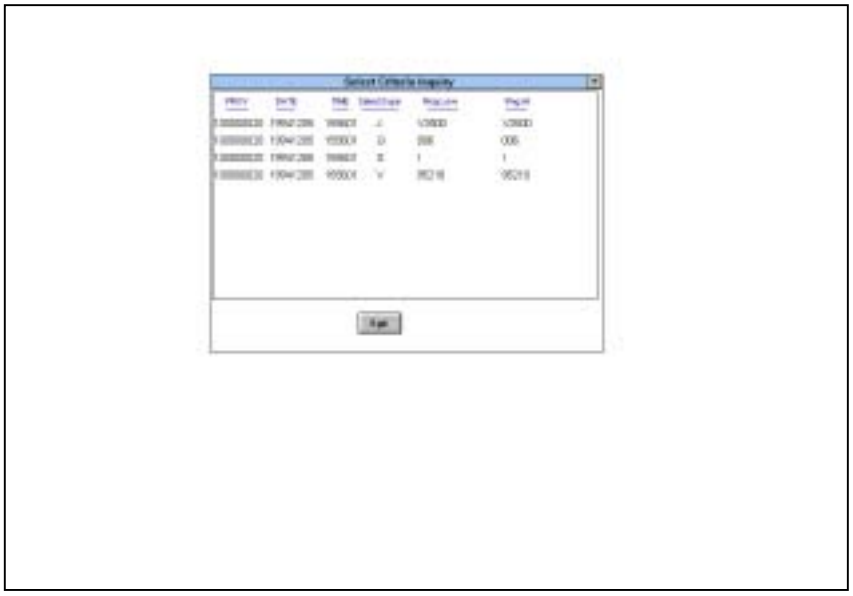


Figure 5 – Select Criteria Inquiry Window

Window Definition: SUR Claim Listing

Introduction

The SUR Claim Listing Window presents a listing of the selected claims that meet the user-selected criteria of the corresponding request on the Provider History/Sample Request Window. The claims are identified by ICN. Displayed claim information includes RID, from date of service, billed and paid amounts, and the paid date.

Claim listings will remain on line for 7 calendar days, at which time they will be automatically purged from the file. Four function buttons are available to further process the data as described in the following field definitions. Options such as report hardcopy, worksheet, and medical record request generation are possible through use of the function buttons.

The SUR Claim Listing Window will be accessed utilizing the mouse by clicking the Claim List button on the SUR Provider History/Sample Request Window. Keyboard access is available from the SUR Provider History/Sample Request Window by pressing the Alt key simultaneously with the letter C. Access is also available from the Option menu bar on the Provider Select and SUR Provider History/Sample Request Windows.

Detailed Field Information

Field Name: NO.

Description – The claim listing sequence number

Format – Four character numeric

Features – System generated

Edits – None

To correct – N/A

Field Name: ICN

Description – The internal control number of each claim listed

Format – Twelve character numeric

Features – System generated

Edits – None

To correct – N/A

Field Name: RID

Description – The recipient Medicaid identification number for each claim listed

Format – Twelve character numeric

Features – System generated

Edits – None

To correct – N/A

Field Name: FDOS

Description – The from date of the first detail carried on file for each claim listed

Format – MM/DD/YY

Features – System generated

Edits – None

To correct – N/A

Field Name: BILLED

Description – The billed amount of each claim listed

Format – Nine character numeric

Features – System generated

Edits – None

To correct – N/A

Field Name: PAID

Description – The paid amount of each claim listed

Format – Nine character numeric

Features – System generated

Edits – None

To Correct – N/A

Field Name: PD DTE

Description – The remittance date of each claim listed

Format – MM/DD/YY

Features – System generated

Edits – None

To correct – N/A

Field Name: HARDCOPY

Description – Clicking the listed HARDCOPY button will submit the sample for production of a hard copy SURS Selected Provider Detail Report for the claims listed

Format – N/A

Features – Click to submit sample for hard copy production

Edits – None

To correct – N/A

Field Name: WORKSHEET

Description – Clicking the WORKSHEET button will submit the sample for production of a worksheet for each claim listed

Format – N/A

Features – Click to submit sample for worksheet production

Edits – None

To correct – N/A

Field Name: MED REC

Description – Clicking the MED REC button will submit the sample for production of a medical records request form for the claims listed

Format – N/A

Features – Click to submit sample for medical records request form production

Edits – None

To Correct – N/A

Field Name: STORE

Description – Clicking the STORE button will store the sample on line for 7 additional calendar days from the current date. Storing the sample will automatically reset the REQUEST DATE and REQUEST TIME to the current date and time. If a sample is not "stored" using the STORE button, it will be systematically purged from the file in 7 calendar days from the original request date.

Format – N/A

Features – Click to store sample

Edits – None

To correct – N/A

Window Example: SUR Claim Listing

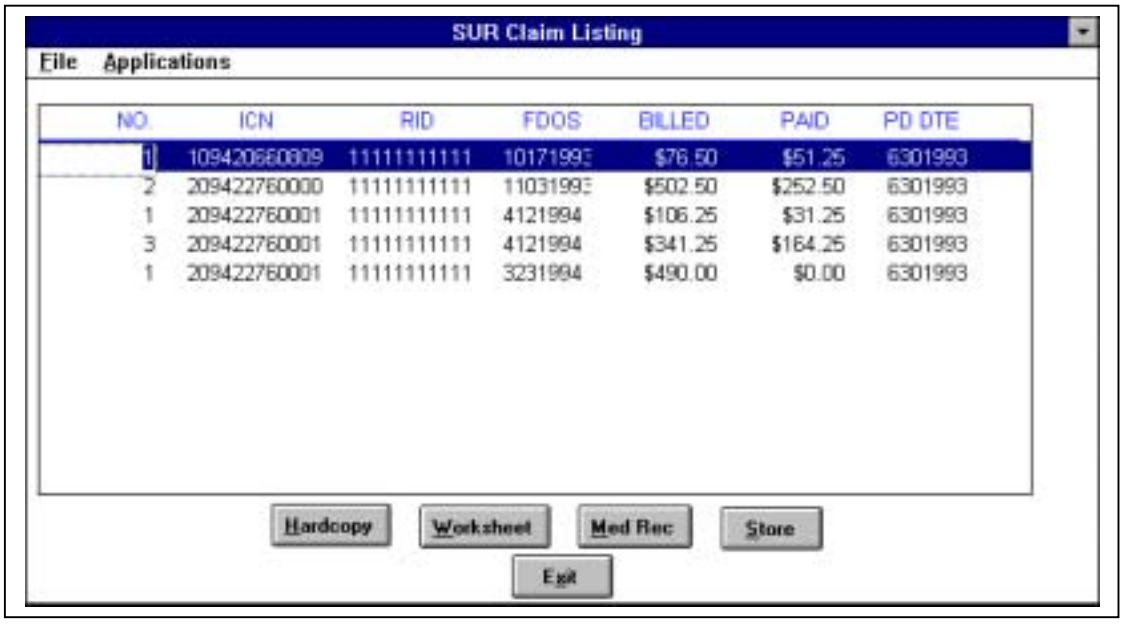


Figure 6 – SUR Claim Listing Window

Window Definition: Statistical Summary for Sample Request

Introduction

The Statistical Summary for Sample Request Window provides volume information to be used in determining sample size when requesting histories and samples on the SUR Provider History/Sample Request Window.

The Statistical Summary for Sample Request Window will be accessed utilizing the mouse by clicking the Stats button on the SUR Provider History/Sample Request Window. Keyboard access is available from the SUR Provider History/Sample Request Window by pressing the Alt key simultaneously with the letter t. Access is also available from the Option menu bar on the Provider Select and SUR Provider History/Sample Request Windows.

Detailed Field Information

Field Name: FOR:

Description – The SURS reporting master file date range as carried on the SUR Options Control File ("10-File")

Format – MM/DD/YY - MM/DD/YY

Features – System generated

Edits – None

To correct – N/A

Field Name: PROVIDER NUMBER

Description – The provider's Medicaid ID number

Format – Nine character numeric

Features – System plug from calling window

Edits – None

To correct – N/A

Field Name: RECIPIENTS: MEDICAID

Description – The unduplicated number of Medicaid recipients with Medicaid services billed by the referenced provider during the reporting period.

Format – five character numeric

Features – System generated

Edits – None

To correct – N/A

Field Name: RECIPIENTS: MEDICARE

Description – The unduplicated number of Medicaid recipients with Medicare services billed by the referenced provider during the reporting period.

Format – Five character numeric

Features – System generated

Edits – None

To correct – N/A

Field Name: CLAIMS

Description – The number of claims submitted by the referenced provider for each of the claim types the provider has billed during the reporting period.

Format – Four character numeric

Features – System generated

Edits – None

To Correct – N/A

Field Name: SERVICES

Description – The number of services billed by the referenced provider for each of the claim types listed during the reporting period.

Format – Six character numeric

Features – System generated

Edits – None

To correct – N/A

Field Name: BILLED AMT

Description – The amount billed by the referenced provider for each of the claim types listed during the reporting period.

Format – Nine character numeric

Features – System generated

Edits – None

To correct – N/A

Field Name: PAID AMT

Description – The amount paid to the referenced provider for each of the claim types listed during the reporting period.

Format – Nine character numeric

Features – System generated

Edits – None

To correct – N/A

Field Name: TOTAL: (claims, services, billed $. paid $)

Description – The total number of claims, services, amounts billed and paid for all claim types for the referenced provider during the reporting period.

Format – Same as individual fields

Features – System generated

Edits – None

To correct – N/A

Window Example: Statistical Summary for Sample Request

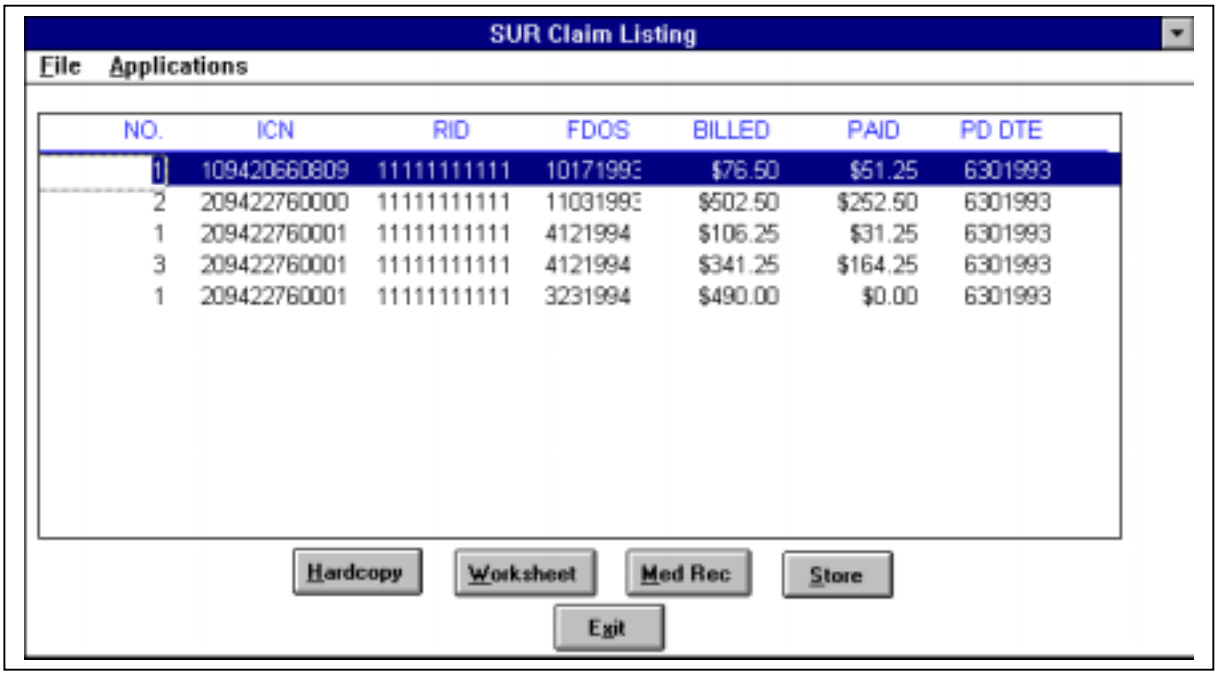


Figure 7 – SUR Claim Listing Window

Report Definition: SUR-1300-D Selected Provider Detail

Part I Report Definition Information

Functional Area:	SURS
Report Number:	SUR-1300-D
Job Name:	SRGJD133
Report Title:	Selected Provider Detail

Description of Information

The Selected Provider Detail Report contains one to thirty six months of claims details for selected providers based on either date of payment or date of service. Numerous sort and selection criteria are available to customize the report to meet the user's specific detail reporting needs. A full claim history or a random sample of claims may be requested. The report includes a summary of activity by procedure, diagnosis, DRG, explanation of benefit code and place of service at the end of each detail

listing. The provider numbers and sort / select criteria are logged for generation by the SURS user on the SUR Provider History/Sample Request Window, and requested for laser print by clicking the "HARDCOPY" button on the resulting SUR Claim Listing Window.

Purpose of Report

The Selected Provider Detail Report is used to research and document specific instances of abuse. Often a review of the history details uncovers certain patterns that are not detectable with other reports. The optional selection and sort criteria provides a process to generate claims data at the request of the user, so that only information which is of value in making a determination of misutilization is displayed for the user. A listing of the available select and sort criteria is found in the field descriptions for the SUR Provider History/Sample Request Window, documented in SUR Set 2.

Sort Sequence

Optional

Distribution

Distribution	Media	Copies	Frequency
IFSSA	Hardcopy	One copy	On Request
EDS	Hardcopy	One copy	On Request

Selected Provider Detail

Part II Report Definition Information

Functional Area: SURS

Report Number: SUR-1300-D

Detailed Field Definitions

Table 6.13 – Field Description

Field	Description
Req By:	The user defined identification code of the report requestor.
Period	The time frame reflected by the data on the report.
Selection Criteria	The select criteria reflected by the data on the report.
Sort Sequence	The sort criteria reflected by the data on the report.

Table 6.13 – Field Description

Field	Description
Prov	Information identifying the provider including medical identification number, name, and address.
G/I	This field indicates whether or not the provider is a group provider ('G' = group provider, 'I' = individual)
Detail Locality	The provider's original locality code and description.
Typ	The provider's original type code and description.
Spc	The provider's original specialty code
RID	The recipient's medical identification number.
Name	The recipient's last name, first name.
Sex	The recipient's sex (F = female, M = male)
Age	The recipient's age at the time of the first claim listed under that recipient's number.
ICN	The internal control number for this claim.
PMT IND	Pay class for the service for this provider. A – assigned N - non-assigned B - billed but not performed by this provider O - ordered or referred by this provider but not performed
FDOS	The beginning date of service in MM/DD/CCYY format.
TDOS	The ending date of service in MM/DD/CCYY format.
POS	The code representing the place of service.
NO SVCS	The number of services for this recipient.
Unit SVC	The number of prescribed units for drug claims or performed units for all other claims.
BLD AMT	The amount billed for each procedure code.
ALW AMT	The amount allowed for each procedure code according to the Pricing File.
CLM PAID	The amount actually paid by Medicaid for the entire claim.
PD DT	The date the claim is paid in MM/DD/CCYY format.
RA NUM	The Remittance Advice Number on which the claim is paid.
SEC DIAG	This field contains the secondary diagnosis reported for a medical service.
ATT PROV	The Medical Assistance identification number of the physician attending the recipient, for inpatient hospital claims.
DTL#	The number assigned in sequential order to detail claims connected to the same ICN. The first detail is 01, second 02, etc.
PRIM DIAG	The detail diagnosis code which is listed on the claim and its description.
MOD	The procedure modifier code.
PROC	The procedure code, or procedure identification code.
DESC	The procedure code description.

Table 6.13 – Field Description

Field	Description
MODIFIED DESC	The description of the procedure/modifier/taxonomy combination that is associated with the procedure identification code.

Table 6.14 – Recipient Totals:

Field	Description
Svcs	The total number of services provided to the recipient.
Units of Service	The total units of service provided to the recipient.
Billed Amount	The total amount billed for the recipient.
Allw	The total amount allowed for claims for the recipient.
Claims	The total number of claims for the recipient.

Table 6.15 – Provider Totals:

Field	Description
Code	The code or being reported.
Description	The description of the code.
Svcs	The total number of services for the code.
Quantity	The total quantity for the code.
Billed	The total billed amount for the code.
Allowed	The total allowed amount for the code.

Table 6.16 – Pay Group Totals:

Medicaid, Package C, Medicare, Total, Billed, Ordered	
Field	**Description**
Recipients	The total number of recipients who had services in each payment class.
Services	Total number of services for all recipients in each payment class.
Amt Billed	Total billed amount for all services in each payment class.
Amt Allowed	Total allowed amount for all services in each payment class.
Amt Paid	Total paid amount for all services in each payment class.
Deductible	Total deductible amount for all services in each payment class.
Claims	Total number of claims for all recipients in each payment class.

Report Example: SUR Selected Provider Detail (1 of 3)

```
  REPORT:  SUR-1300- D                                  INDIANAAIM                                  PAGE NUM:     1
 PROCESS:  SRGJD133                                                                               RUN DATE:  10/07/2003
LOCATION:  SRGP1302                              SELECTED PROVIDER DETAIL REPORT

REQ BY: XXX                                (SAMPLE SIZE:       5   RANDOM  100)        PERIOD:   01/01/2001 THRU 09/30/2003

   SELECTION CRITERIA
  PROCEDURE/MODIFIER CODE     D5120GE            - D5120GE             D0120  59          - D0120  59
                              D1525              - D1525               D213180           - D213180
                              D0160              - D0160               D1550KM           - D1550KM
SORT SEQUENCE:  RECIPIENT NAME           ICN                      DATE OF SERVICE

PROV  999999999 -XXXXX            XXXXXX           XXX XXXX XXX         XXX XXXXXX          XX  XXXXX            G/I I
DETAIL-- LOCALITY  XX    XXXXX                 TYP   027  Dentist                  SPC   271  GENERAL DENTISTRY PRACTI

              PMT                        NO    UNIT  ------------  AMOUNTS  -------------     PD      RA                   ATT
      ICN     IND  FDOS     TDOS   POS  SVCS    SVC    BLD AMT      ALW AMT    CLM PAID       DT      NUM                  PROV

************** RID  XXXXXXXXXXXX       NAME  XXXXX         XXXXXXX                          SEX  M      AGE   XX   ***************

  XXXXXXXXXXXX X XX/XX/XX XX/XX/XX  00    1      1.00      100.00      100.00      100.00 XX/XX/XX-999999999
PGM M   DTL # 001 PRIM DIAG                                          SEC DIAG                                    BP
PROC D5120       GE                 MOD    DESC COMPLETE LOWER (DENTURE)***EFFECTI MODIFIED DESC DESC 1 TESTING

  XXXXXXXXXXXX X XX/XX/XX XX/XX/XX  00    1      1.00      125.00      125.00      125.00 XX/XX/XX 999999999
PGM M   DTL # 001 PRIM DIAG                                          SEC DIAG                                    BP
PROC D2131       80                 MOD    DESC AMALGAM-FOUR SURFACES, PRIMARY     MODIFIED DESC DESC 1 TEST PRICING MOD IN POSITIO

  XXXXXXXXXXXX X XX/XX/XX XX/XX/XX  00    1      1.00       35.00       35.00       35.00 XX/XX/XX 999999999
PGM M   DTL # 001 PRIM DIAG                                          SEC DIAG                                    BP
PROC D5120       GE                 MOD    DESC COMPLETE LOWER (DENTURE)***EFFECTI MODIFIED DESC DESC 1 TESTING

  XXXXXXXXXXXX X XX/XX/XX XX/XX/XX  00    1      1.00       50.00       50.00       50.00 XX/XX/XX 999999999
PGM M   DTL # 001 PRIM DIAG                                          SEC DIAG                                    BP
PROC D0160                         MOD    DESC DETAILED AND EXTENSIVE ORAL EVALUA MODIFIED DESC

  RECIPIENT TOTALS  SVCS       4 UNITS OF SERVICE         4.00 BILLED AMOUNT      310.00  ALLW      310.00         CLAIMS     4

************** RID  XXXXXXXXXXXX       NAME  XXXXX         XXXXX                            SEX  F      AGE   XX   ***************

  XXXXXXXXXXXX X XX/XX/XX XX/XX/XX  00    1      1.00      145.75      145.75      145.75 XX/XX/XX 999999999
PGM M   DTL # 001 PRIM DIAG                                          SEC DIAG                                    BP
PROC D1525                         MOD    DESC SPACE MAINTAINER - REMOVABLE-BILAT MODIFIED DESC

  RECIPIENT TOTALS  SVCS       1 UNITS OF SERVICE         1.00 BILLED AMOUNT      145.75  ALLW      145.75         CLAIMS     1
```

Report Example: SUR Selected Provider Detail (2 of 3)

```
  REPORT:  SUR-1300- D                                   INDIANAAIM                                         PAGE NUM:     2
 PROCESS:  SRGJD133                                                                                         RUN DATE:  10/07/2003
LOCATION:  SRGP1302                                SELECTED PROVIDER DETAIL REPORT

REQ BY: XXX                                     (SAMPLE SIZE:       5   RANDOM  100)         PERIOD:   01/01/2001 THRU 09/30/2003


PROV  XXXXXXXXX XXXXXX            XXXXX           XXX XXXX XXX          XXX XXXXXXX         IN  XXXXX            G/I I
DETAIL-- LOCALITY  XX    XXXXX                  TYP   027  Dentist                       SPC   271  GENERAL DENTISTRY PRACTI


**** PROVIDER TOTALS ***


   PROC                       DESCRIPTION               MODIFIED DESCRIPTION        SVCS    QUANTITY      BILLED        ALLOWED

D5120      GE               COMPLETE LOWER (DENTURE)***E  DESC 1 TESTING                2        2.00      135.00         135.00
D2131      80               AMALGAM-FOUR SURFACES, PRIMA  DESC 1 TEST PRICING M         1        1.00      125.00         125.00
D0160                       DETAILED AND EXTENSIVE ORAL                                 1        1.00       50.00          50.00
D1525                       SPACE MAINTAINER - REMOVABLE                                1        1.00      145.75         145.75

   THERAPEUDIC CLASS          DESCRIPTION               MODIFIED DESCRIPTION        SVCS    QUANTITY      BILLED        ALLOWED

                                                                                        5        5.00      455.75         455.75

   PROGRAM                    DESCRIPTION               MODIFIED DESCRIPTION        SVCS    QUANTITY      BILLED        ALLOWED

 M                          MEDICAID                                                    4        4.00      355.75         355.75
                            MEDICAID                                                    1        1.00      100.00         100.00
```

Report Example: SUR Selected Provider Detail (3 of 3)

```
  REPORT:  SUR-1300- D                          INDIANAAIM                                  PAGE NUM:     3
 PROCESS:  SRGJD133                                                                        RUN DATE:  10/07/2003
LOCATION:  SRGP1302                       SELECTED PROVIDER DETAIL REPORT

REQ BY: DKE                             (SAMPLE SIZE:       5   RANDOM  100)        PERIOD:   01/01/2001 THRU 09/30/2003


PROV  XXXXXXXXX XXXXXX            XXXXXX          XXX XXXX XXX         XXX XXXXXX          IN  XXXXX            G/I I
DETAIL-- LOCALITY  XX    XXXXX                  TYP   027  Dentist                  SPC   271  GENERAL DENTISTRY PRACTI


**** PROVIDER TOTALS ***

   POS                      DESCRIPTION              MODIFIED DESCRIPTION        SVCS    QUANTITY      BILLED         ALLOWED

 00                       PHARMACY                                                5        5.00         455.75         455.75

      PAY GROUP        RECIPIENTS   SERVICES      AMT BILLED        AMT  ALLOWED       AMT PAID          DEDUCTIBLE      CLAIMS

      MEDICAID              2            5.00          455.75           455.75           455.75           0.00            5
      MEDICARE              0            0.00            0.00             0.00             0.00           0.00            0
      TOTAL                 2            5.00          455.75           455.75           455.75           0.00            5
      BILLED                0            0.00            0.00             0.00             0.00           0.00            0
      ORDERED               0            0.00            0.00             0.00             0.00           0.00            0
```

Report Definition: SUR-1320-D SURS Provider Detail History Summary

Part I Report Definition Information

Functional Area: SURS

Report Number: SUR-1320-D

Job Name: SRGJQ120

Report Title: SURS Provider Detail History Summary

Description of Information

The SURS Provider Detail History Summary provides a summary of each provider's claim activity for the current reporting period. Claim activity is ranked by procedure, diagnosis, EOP and DRG, with cumulative number of services, billed, allowed, paid and denied dollars reported for each code. Claim class totals are also reported.

Purpose of Report

The SURS Provider Detail History Summary may be used by the SUR analyst to quickly analyze the provider's overall code usage. Claim detail data may be obtained if needed, by requesting a Selected Provider History Detail Report.

Sort Sequence

Provider number, rank order by code category (Procedure, EOP, diagnosis, DRG)

Distribution, Media, Copies, and Frequency

Distribution	Media	Copies	Frequency
IFSSA	Hardcopy	One Copy	On Request
EDS	Hardcopy	One Copy	On Request

SUR Provider Detail History Summary

Part II Report Definition Information

Functional Area: SURS

Report Number: SUR-1320-D

Detailed Field Definitions

Table 6.17 – Field Description

Field	Description
Reporting Period	The time frame reflected by the data on the report.
Provider	Information identifying the provider including medical identification number, name, and address.
Primary Specialty	The provider's primary specialty code.
Type	The provider's type code.
[Code]	The code being reported.
Description	The description of the code.
Svcs	The total number of services for the code.
Qnty	The total quantity for the code.
Denied	The total number of services denied for the code.
$Billed	The total billed amount for the code.
$Allowed	The total allowed amount for the code.
$Paid	The total paid amount for the code.
$Denied	The total amount denied for the code.

Table 6.18 – Claim Class Totals:

Summary information for each of the claim classes:	
	NI – Non-Institutional
	IP – Inpatient
	OP – Outpatient Hospital
Field	**Description**
Pts	The number of patients with claims in this claim class
Claims	The number of claims in this claim class
Qnty	The total quantity billed in this claim class
Denied	The total quantity denied in this claim class
$Billed	The total dollars billed in this claim class

Table 6.18 – Claim Class Totals:

Summary information for each of the claim classes:	
	NI – Non-Institutional
	IP – Inpatient
	OP – Outpatient Hospital
Field	**Description**
$Paid	The total dollars paid in this claim class
$Denied	The total dollars denied in this claim class

Report Example: SURS Provider Detail History Summary

```
  REPORT:  SUR-1320- D                                INDIANAAIM                                      PAGE NUM:     1
 PROCESS:  SRGJD133                                                                                   RUN DATE:  10/26/2000
LOCATION:  SRGP1302                      SURS PROVIDER DETAIL HISTORY SUMMARY

REQ BY: XXXX                             (SAMPLE SIZE:    1,227   RANDOM  100)        PERIOD:   04/01/1999 THRU 06/30/2000


PROV  999999999 LAMARCA            BRIDGET            BRIDGET C LAMARCA     INDIANAPOLIS         IN  46202            G/I I
DETAIL-- LOCALITY  49    Marion                    TYP   015  Chiropractor               SPC   150  CHIROPRACTOR


**** PROVIDER TOTALS ***
```

PROC	DESCRIPTION	SVCS	QUANTITY	BILLED	ALLOWED
98941	CHIROPRACTIC MANIPULATIVE	2,019	2,019.0	70,665.00	50,957.72
97033	APPLICATIION OF A MODALIT	658	658.0	13,230.00	7,129.56
98941	CHIROPRACTIC MANIPULATIVE	2,019	2,019.0	70,665.00	50,957.72
97033	APPLICATIION OF A MODALIT	658	658.0	13,230.00	7,129.56
98941	CHIROPRACTIC MANIPULATIVE	2,019	2,019.0	70,665.00	50,957.72
97033	APPLICATIION OF A MODALIT	658	658.0	13,230.00	7,129.56
98941	CHIROPRACTIC MANIPULATIVE	2,019	2,019.0	70,665.00	50,957.72
97033	APPLICATIION OF A MODALIT	658	658.0	13,230.00	7,129.56
98941	CHIROPRACTIC MANIPULATIVE	2,019	2,019.0	70,665.00	50,957.72
97033	APPLICATIION OF A MODALIT	658	658.0	13,230.00	7,129.56
98941	CHIROPRACTIC MANIPULATIVE	2,019	2,019.0	70,665.00	50,957.72
97033	APPLICATIION OF A MODALIT	658	658.0	13,230.00	7,129.56
98941	CHIROPRACTIC MANIPULATIVE	2,019	2,019.0	70,665.00	50,957.72
97033	APPLICATIION OF A MODALIT	658	658.0	13,230.00	7,129.56
98941	CHIROPRACTIC MANIPULATIVE	2,019	2,019.0	70,665.00	50,957.72
97033	APPLICATIION OF A MODALIT	658	658.0	13,230.00	7,129.56
98941	CHIROPRACTIC MANIPULATIVE	2,019	2,019.0	70,665.00	50,957.72
97033	APPLICATIION OF A MODALIT	658	658.0	13,230.00	7,129.56

Report Definition: SUR-1308-D SUR Non-Institutional Worksheet

Part I Report Definition Information

Functional Area:	SURS
Report Number:	SUR-1308-D
Job Name:	SRGJD133
Report Title:	SUR Non-Institutional Worksheet

Description of Information

The SUR Non-Institutional Worksheet is an on-request report generated from the History/Sample generation function for provider types other than Type 01, Hospital. General claim information is printed on the report, such as recipient name and RID, ICN, dates of service, amounts billed and paid. In addition to claim information, each worksheet report provides spaces for SUR Analyst use and a denial reason key to correspond with Analyst determinations, referenced by code.

Purpose of Report

When, after reviewing the history/sample data, it is determined that the SUR analyst must review a provider's medical records, an SUR Non-Institutional Worksheet Report may be generated by clicking the WORKSHEET button on the specific SUR Claims Listing Window. The worksheets will then be used during the medical record audit to verify that the provider can substantiate the services billed to Medicaid.

Sort Sequence

Recipient Last Name, First Name

Page break at each new claim

Distribution

Distribution	Media	Copies	Frequency
EDS	Hardcopy	One copy	On Request

SUR Non-Institutional Worksheet

Part II Report Definition Information

Functional Area: SURS

Report Number: SUR-1380-D

Detailed Field Definitions

Table 6.19 – Header Information

Field	Description
Period	The time frame reflected on the entire report (all worksheets).
Denial Reason Code Key	A description key to the denial reason codes that may be used by the SUR Analyst in outcome determination.
Provider	Provider's name (last, first) and Medicaid identification number.

Table 6.20 – Detail Information

Field	Description
RID	The recipient identification number.
Last Name, FI.	The recipient's name (last, first).
ICN	The internal control number of the claim.
FDOS	The from date of service of the claim detail.
TDOS	The to date of service of the claim detail.
Units	The number of units billed for the procedure code on the claim detail.
Proc	The procedure code, or procedure identification code billed on the claim detail.
Description	The procedure code description.
MODIFIED DESC	The description of the procedure/modifier/taxonomy combination that is associated with the procedure identification code.
Billed	The amount billed for the claim detail.
Allowed	The amount allowed for the claim detail.
# Denied	A blank field to be used by the SUR Analyst when denying units of service subsequent to medical record review.
$ Denied	A blank field to be used by the SUR Analyst when denying payment subsequent to medical record review.
RSN	The reason code for the review outcome determination.

Table 6.21 – Claim Total

Field	Description
Units	The total number of units billed for the entire claim.
Billed	The total amount billed for the entire claim.
Allowed	The total amount allowed for the entire claim.
# Denied	A blank field to be used by the SUR Analyst when denying units of service subsequent to medical record review.
$ Denied	A blank field to be used by the SUR Analyst when denying payment subsequent to medical record review.

Report Example: SUR Non-Institutional Worksheet

```
REPORT:  SUR-1308-D                              IndianaAIM                                DATE:  10/08/2003
 PROCESS:  SRGJD133                        SUR Non-Institutional Worksheet                  TIME:  14:42:43
LOCATION:  SRGP1382                       (Period 01/01/2001 - 09/30/2003)                 PAGE:       1
                                          (SAMPLE SIZE:       1   RANDOM  100)

Selection Criteria

  PROCEDURE/MODIFIER CODE     80069              - 80069


Denial Reason Code Key:

 1.Not Ordered                          8.Does not Meet Criteria for Injection     15.Service Denied,Recoup Overhead Code
 2.Not Verified                         9.Incorrect Units of Service               16.No Doco to Support Medical Necessity
 3.Not Covered                         10.Duplicate Billing                        17.Office Visit Included with Surgery
 4.No Doco to Support Services Rendered 11.Inappropriate Procedure Ident Code      18.No Odometer Reading
 5.Fragmentation of Another Charge      12.Not Signed by Recip/Prov/Medical Service 19.No Signature/Proof of Delivery
 6.No Tx Plan for DOS/Phys Review > 60 Days 13.Time Unsubstantiated by Documentation  20.Phys Order Date Not Specifically Ident
7.No Tx Plan for DOS/Phys Review > 90 Days 14.Not Signed by Rendering/Supervising Phys 21.No Doco for Level of Service/Recoup Diff

PROVIDER:    XXXXXXXX,                          XXXXXXXXX

RID           LAST NAME      FI
XXXXXXXXXXX   XXXXX           X

ICN              FDOS       TDOS    UNITS     PROC                      DESCRIPTION                  MODIFIED DESCRIPTION

XXXXXXXXXXXX XX/XX/XXXX-XX/XX/XX    1    800698091AW           RENAL FUNCTION PANEL              TESTING FOR SUR PRICING MODIFIE
                                                                      $       25.00  $       25.00 _________ ___________ ___ PGM M

                                    UNIT                      PAID          BILLED       ALLOWED
PGM C TOTAL:                         0                                $        0.00  $        0.00 _________ ___________
PGM M TOTAL:                         1                                $       25.00  $       25.00 _________ ___________
CLAIM TOTAL:                         1                  $      25.00  $       25.00  $       25.00 _________ ___________
```

Report Definition: SUR-1309-D Medical Records Request

Part I Report Definition Information

Functional Area: SURS

Report Number: SUR-1309-D

Job Name: SRGJD133

Report Title: Medical Records Request

Description of Information

The Medical Records Request Report is an on-request claim listing generated from the History/Sample generation function. General claim information that a provider would need in order to fill a request for medical records is printed on the report (such as recipient name, RID, ICN, dates of service, etc.).

Purpose of Report

When, after reviewing the history/sample data, it is determined that the SUR analyst requires the provider's medical records to complete a review, a Medical Records Request Report may be generated by clicking the MED REC button on the specific SUR Claims Listing Window. The Medical Records Request Report will then be transmitted to the provider, with a letter explaining the process and expectations.

Sort Sequence

Recipient Last Name, First Name

Distribution

Distribution	Media	Copies	Frequency
EDS	Hardcopy	Two copies	On Request

Medical Records Request

Part II Report Definition Information

Functional Area: SURS

Report Number: SUR-1309-D

Detailed Field Definitions

Table 6.22 – Header Information

Field	Description
Period	The time frame reflected on the report.
Sample Size	The total number of claims listed on the request.
Provider Name	The provider's name (last, first).
Medicaid ID	The provider's Medicaid identification number.
Group ID	The group Medicaid identification number to which the provider is associated, if applicable.
LOC	The detail locality code.
TYP	The detail provider type code.
SPC	The detail provider primary specialty code.

Table 6.23 – Detail Information

Field	Description
Recipient Name	The Recipient’s name (last, first).
RID	The recipient's Medicaid identification number.
Birthdate	The recipient's birth date.
Age	The recipient's age.
ICN	The internal control number of the claim.
FDOS/Admit	For claim type I, the date of admission. For all other claim types, the from date of service from the claim details.
TDOS/Dschg	For claim type I, the date of discharge. For all other claim types, the to date of service from the claim details.

Report Example: Medical Record Request

```
  REPORT:  SUR-1309-D                    IndianaAIM                     DATE:  10/25/2000
 PROCESS:  SRGJD133               Medical Records Request              TIME:  18:42:02
LOCATION:  SRGP1392           (Period 01/01/2000 - 04/30/2000)         PAGE:       1
                            (SAMPLE SIZE:          2   RANDOM  0.5)


PROVIDER NAME            MEDICAID ID        GROUP ID         LOC        TYP        SPC
MCDANIEL                 999999999                           06         031        316


     RECIPIENT NAME (LAST, FIRST)  BIRTHDATE   AGE      ICN         FDOS/ADMIT TDOS/DSCHG
     RID

  1  9999              999999    99/99/9999   99   9999999999999   03/18/2000 03/18/2000
     999999999999

  2  9999              9999      99/99/9999  99   9999999999999   02/12/2000 02/12/2000
     999999999999

  3  9999              999999    99/99/9999   99   9999999999999   03/18/2000 03/18/2000
     999999999999

  4  9999              9999      99/99/9999   99   9999999999999   02/12/2000 02/12/2000
     999999999999

  5  9999              999999    99/99/9999   99   9999999999999   03/18/2000 03/18/2000
     999999999999

  6  9999              9999      99/99/9999   99   9999999999999   02/12/2000 02/12/2000
     999999999999
```

Recipient Summary Reporting

The Recipient Summary Profile Reports are similar to the Provider Summary Profile Reports and provide a summary of the medical activity for all recipients and all recipient peer groups. The peer group's activity is compared to the individual's activity. Those parameters on which the individual has deviated from the allowable values will be indicated and exception weight will be assigned. The Recipient Summary Profile Exception Ranking Report ranks the recipients in descending exception weight order.

The report line items for the activity summaries are defined by the user and should be oriented to potential areas of abuse by the recipients. A different set of line items can be established for each of the nine possible COS report images if desired.

Reports produced are:

- Recipient Summary Profile (Exceptions) Report
- All Recipient Summary Report
- Selected Recipient Summary Report
- Recipient Exception Deselection Report
- Recipient Peer Group Summary Profile Report
- Recipient Summary Profile Exceptions Statistics Report
- Recipient Summary Profile (Forced) Report
- Recipient Summary Profile Ranking Report

The Recipient Summary Profiles provide a volume analysis of a recipient's Medical Assistance activity in comparison to the activity of that recipient's peers. The profiles can be used to detect potential areas of abuse, misutilization, or fraud. In addition, the report can be designed to indicate a lack of care on the part of the provider(s) treating the recipient. The user determines what aspects of recipient activity are monitored according to the types and cost of services covered under various programs. Quality of care, recipient abuse, or a combination of the two can be assessed by selection of appropriate line items. Recipient Summary Profiles can also be used as additional documentation in a provider case review.

Report Definition: SUR-3500-Q Recipient Summary Profile (Exceptions)

Part I Report Definition Information

Functional Area: SURS

Report Number: SUR-3500-Q

Job Name: DSIBMU34

Report Title: Recipient Summary Profile (Exceptions)

Description of Information

The Beneficiary Summary Profile (Exceptions) Report provides the user with a statistical summary of a recipient's activity during the time periods that are being reported. The purpose of this report is to monitor significant characteristics of recipient utilization based on user-defined parameters. Exceptional patterns of utilization are identified based on either a percentage difference from the peer group average, a fixed value, or a standard deviation. Exception weight is assigned based on the level of deviation. This report is produced when a recipient's exception weight places him within the top X% of exception recipients and the recipient meets the user-defined minimums for exception reporting.

Purpose of Report

A recipient's summary profile is used to perform the initial review of the recipient's utilization. The key to effective use of the summary profile is to have appropriate parameters with line items designed to detect potential areas of abuse by the recipients. The limits should be defined sufficiently above or below the peer group averages so that only those recipients who have deviated most significantly are flagged. Recipients are not flagged for exception on line items which have not been assigned an exception limit. A limit is established for every selected parameter to detect misutilization.

Sort Sequence

Recipient peer group, recipient number

Distribution

Distribution	Media	Copies	Frequency
EDS	CRLD		Quarterly
IFSSA	CRLD		Quarterly

Recipient Summary Profile (Exceptions)

Part II Report Definition Information

Functional Area: SURS

Report Number: SUR-3500-Q

Detailed Field Definitions

Table 6.24 – Field Description

Filed	Description
Period	The time frame reflected by the data on the report.
Report Sequence	The report sequence for which data is being reported.
Report Location	The recipient's peer group location code and description.
Aid Category	The recipient's peer group aid category code and description.
LTC	A 'Y' in the field indicates that the peer group is comprised of long term care recipients.
Age	The group code for age assigned to this peer group when the age option is used.
Sex	The sex code for this peer group when the sex option is used F = female, M = male and B = both.
Race	The race code for this peer group when the race option is used.
Spec Pr	The special program code for this peer group when the special program option is used.
Detail Location	The recipient's original location code and description.
Aid Category	The recipient's original aid category code and description.
LTC	A 'Y' in the field indicates the individual currently resides in a nursing home according to the eligibility file.
Age	The recipient's actual age at the time the report is produced.
Sex	The recipient's actual sex code (F = female, M = male, B = both)
Race	The recipient’s original race code, when the race option is used.
Spec Pr	The recipient’s original special program code, when the special program option is used.
RID	The recipient's current medical identification number.
Name	The recipient's last name, first name, and middle initial.
Case Number	The recipient's family head of household SSN.
Birth	The recipient's date of birth in MM/DD/CCYY format.
Start Date	The date eligibility started for the RID number.
Race	The recipient's race code.

Table 6.24 – Field Description

Filed	Description
Reference Period	The reporting period selected by the user as the period on which the peer group averages are to be computed.
FYTD Period	The fiscal year-to-date period which defines data to be included in the FYTD totals at the bottom of the report. The dates displayed in this field begin with the first month of the current fiscal year and end with the last month of data being reported. Currently set at July.
Reference Period Peer Grp Count	The total number of recipients in the peer group who have data in the reference period and whose activity is used to compute the peer group averages.
Tot Wgt	The recipient's total exception weight for all reporting periods. This weight represents a measure of deviation from the expected values for all data elements noted as exceptions.
Period Weight Multiplier	A factor the user selects through the 10 control file with which the computed exception weight is multiplied for each of the reporting periods. This enables the user to effect higher weight on exception items in specific reporting periods. Currently 0.5, 0.7, 1.0, 1.0, 1.0.
Minimums for Exception Reporting Billed, 900, Providers, 1, Claims, 6, Services, 6.	User selected activity minimums that must be met before a recipient is considered an exception. A recipient who does not meet these minimums is not reported on the 350 report. These minimums should be used to prevent the generation of 350 reports for recipients whose low volume of activity would not warrant investigation. Minimum values for number of dollars billed, providers, claims, and services can be established by the user to ensure that low volume recipients are not considered exceptions. Low volume recipients receive high exception weight because their averages, percentages, and services are distorted simply because they receive very few services. By setting these minimums at realistic levels, the exception reports produced are more likely to represent valid cases of abuse or misutilization. The values set apply to the recipient's activity during the reference period.
Reporting Period Headers	The month(s) and year(s) for beginning and ending dates for reporting periods 1 through 5.
Activity Summary	A list of user-defined report elements which apply to the report image in which the recipient has activity. Exception limits established by the user for each parameter appear immediately following the line item to which it pertains. Up to 99 line items can be selected by the user according to current needs. Within the recipient category of service, nine different sets of line items are available. The ninth set is considered the 'default' activity summary and applies to all recipients in the category of service whose peer specifications are not specified elsewhere.
Line Item Number	The line item number as defined on the 40 control file.
Line Item Description	The line item description as defined on the 40 control file.

Table 6.24 – Field Description

Filed	Description
Peer Trend	A measure of the change in totals over the five reporting periods for the peer group. TREND = $\frac{100 \text{ X } (2P1 + P2 - P4 - 2P5)}{2 \text{ X } (P1 + P2 + P3 + P4 + P5)}$ P1 represents the most recent reporting period, P2 represents the next most recent reporting period, etc. If less than five periods are reported, the value of unused periods is zero, therefore; the result of the trend calculation may not be valid.
	The Trends field can be suppressed, if the user determines this information is of little value and/or may be misleading.
Indiv Trends	A measure of the change in totals over the five reporting periods for the individual recipient.
Reference Period Weight	A mathematical calculation of the degree of deviation from the expected (peer group) values for each line item in the reference period on which the recipient has exceptional activity. WEIGHT = 100 X $\frac{(\text{INDIV VALUE - PGA})}{\text{PGA}}$ The result of the calculation is then multiplied by the appropriate period weight multiplier. Example: Peer group average = 3 Individual's value = 9 Period Weight Multiplier = Default value 1.0 $\frac{(9 - 3)}{3} = 2 \text{ X } 100 = 200 \text{ X } 1.0 = 200$
Per Gp Avg	The average value of each data element for the entire peer group in the reference period based on the information appearing on the Recipient Peer Group Profile Report.
Line Item Values [Periods 1-5]	The computed values for individual reporting periods (1-5) for each line item.
[Exception Indicator]	'Flags' that appear next to the value of a line item when a recipient deviates outside the range of acceptable values as established by the user. An exception can occur only on line items for which the user sets limits. 'H' is the resulting value for the recipient greater than the high limit. 'L' is the resulting value for the recipient less than the low limit.
Total Exceptions	The total number of exceptions for all reporting periods. The values displayed in the remainder of the line represent the number of exceptions occurring in each reporting period, 1-5.
Total Weight	The accumulated exception weight for all reporting periods. The values displayed in the remainder of the line represent the weight occurring in each reporting period, 1-5.

Table 6.25 – FYTD Totals (Title XIX and XVIII)

Filed	Description
No Svcs	Total number of services submitted for this recipient for the Title XIX and XVIII payment classes.
Amt Billed	Total dollars billed for services received by this recipient for the Title XIX and XVIII payment classes.
Amt Allowed	Total dollars allowed for services received by this recipient for the Title XIX and XVIII payment classes.
Amt Paid	Total dollars paid for services received by this recipient for the Title XIX and XVIII payment classes.
Pct Pd/Bill	Percentage of the amount billed that was paid for services in the Title XIX and XVIII payment classes.

Report Example: Recipient Summary Profile (Exceptions)

```
  REPORT:  SUR-3500- Q                                  INDIANAIM                                                PAGE NUM: 99,999
 PROCESS:  DSIBMU31                                                                                             RUN DATE: 05/08/99
LOCATION:  HUGS350B                  RECIPIENT SUMMARY PROFILE REPORT (EXCEPTIONS)                              RUN TIME: 14:37:56

REPORT SEQUENCE - A                                                                                  PERIOD:   MM YY THRU MM YY

REPORT—LOCATION – L02 - Allen                  AID CATEGORY – AGED – AGED RECIPIENTS                LTC – N/A   AGE 999  SEX  XXX

RACE N/A SPEC PR N/A
DETAIL—LOCATION – 02  - Allen                  AID CATEGORY – A    – AGED MEDICAID                  LTC   N     AGE 999  SEX  XXX

RACE 2   SPEC PR

RID  999999999999   NAME BROWN        CHRISTINE                              CASE NUMBER  9999999999 BIRTH - MM/DD/CCYY

START DATE - MM/DD/CCYY  RACE 2

REFERENCE PERIOD:  MMM YY-MMM YY    FYTD PERIOD -  MMM YY-MMM YY  REFERENCE PERIOD PEER GROUP COUNT -      99,999    TOT WGT -  999,999

PERIOD WEIGHT MULTIPLIERS: 99.9, 99.9, 99.9, 99.9, 99.9

MINIMUMS FOR EXCEPTION REPORTING    BILLED  99999     PROVIDERS  99999   CLAIMS   99999    SERVICES  99999

                                    -----TRENDS----- -REFERENCE PERIOD-    MMM YY    MMM YY    MMM YY    MMM YY    MMM YY
----------ACTIVITY SUMMARY----------      PEER    INDIV  WEIGHT PER GP AVG    MMM YY    MMM YY    MMM YY    MMM YY    MMM YY

01-Amount Billed                     X999.99  X999.99  99,999  99,999.99  999999.99  999999.99  999999.99  999999.99  999999.99 X
02-Amount Paid                       X999.99  X999.99  99,999  99,999.99  999999.99  999999.99  999999.99  999999.99  999999.99 X
03-Percent Paid of Billed            X999.99  X999.99  99,999  99,999.99  999999.99  999999.99  999999.99  999999.99  999999.99 X
04-Number of Claims                  X999.99  X999.99  99,999  99,999.99  999999.99  999999.99  999999.99  999999.99  999999.99 X
05-Number of Recipients              X999.99  X999.99  99,999  99,999.99  999999.99  999999.99  999999.99  999999.99  999999.99 X
06-Avg Amt Billed/Recipient          X999.99  X999.99  99,999  99,999.99  999999.99  999999.99  999999.99  999999.99  999999.99 X
07-Avg Amt Paid/Recipient            X999.99  X999.99  99,999  99,999.99  999999.99  999999.99  999999.99  999999.99  999999.99 X

TOTAL EXCEPTIONS        999,999                                                 99,999     99,999     99,999     99,999     99,999
TOTAL WEIGHT            999,999                                             99,999,999 99,999,999 99,999,999 99,999,999 99,999,999

FYTD TOTALS TITLE XIX     NO SVCS   9999  AMT BILLED 999,999.99    AMT ALLOWED  999,999.99  AMT PAID 999,999.99  PCT PAID/BILLED 999.99
            TITLE XVIII             9999             999,999.99                 999,999.99           999,999.99                 999.99
```

Report Definition: SUR-3510-Q Recipient Summary Profile (Total List)

Part I Report Definition Information

Functional Area: SURS

Report Number: SUR-3510-Q

Job Name: DSIBMU34

Report Title: Recipient Summary Profile (Total List)

Description of Information

The Recipient Summary Profile (Total List) Report provides the user with a summary profile for all recipients who met activity minimums during the reference period. This report is identical in content to the Recipient Exception Summary Profile Report, but because it reports on every recipient (who met the minimums), it is normally much larger in volume.

Purpose of Report

A recipient's summary profile is used to perform the initial review of the recipient's utilization. The key to effective use of the summary profile is to have appropriate parameters with line items designed to detect potential areas of abuse by the recipients. The limits should be defined sufficiently above or below the peer group averages so that only those recipients who have deviated most significantly are flagged. Recipients are not flagged for exception on line items that have not been assigned an exception limit. A limit is established for every selected parameter to detect misutilization.

Sort Sequence

Recipient peer group, recipient number

Distribution

Distribution	Media	Copies	Frequency
EDS	CRLD		Quarterly, on request
IFSSA	CRLD		Quarterly, on request

Recipient Summary Profile (Total List) Report

Part II Report Definition Information

Functional Area: SURS

Report Number: SUR-3510-Q

Detailed Field Definitions

The report field descriptions for the Recipient Summary Profile (Total List) Report are identical to those of the Recipient Summary Profile (Exceptions) Report. Please refer to the report field descriptions section for Recipient Summary Profile (Exceptions) Report for this information.

Report Example: Recipient Summary Profile (Total List)

```
  REPORT:  SUR-3510- Q                              INDIANAIM                                                PAGE NUM: 99,999
 PROCESS:  DSIBMU31                                                                                         RUN DATE: 05/08/99
LOCATION:  HUGS323B                  PROVIDER SUMMARY PROFILE REPORT (TOTAL LIST)                          RUN TIME: 14:37:56

CAT SVC-RPT SEQ 01-A                INDIANA MEDICAID MANAGEMENT INFORMATION SYSTEM

                                                                                                  PERIOD:  MM YY THRU MM YY
PROGRAM: MEDICAID                        CATEGORY OF SERVICE – 01 - INPATIENT

REPORT--LOCATION – IN - INDIANA              TYPE – T01 - Hospital                SPEC          - S010 – ACUTE CARE HOSPITAL
SIZE N/A    ORG. TYP    FACILITY TYPE
DETAIL--LOCATION - 47    - LaPorte           TYPE – 001 - Hospital                SPEC          - 332  - ACUTE CARE HOSPITAL
SIZE 00150  ORG. TYP    FACILITY TYPE

PROV     -  999999999      SMITH K BEN MD                          1509  STATE STREET  #2A    LAPORTE                 IN  45647 G/I G

REFERENCE PERIOD:  MMM YY-MMM YY    FYTD PERIOD -  MMM YY-MMM YY  REFERENCE PERIOD PEER GROUP COUNT -      99,999    TOT WGT -  999,999

PERIOD WEIGHT MULTIPLIERS: 99.9, 99.9, 99.9, 99.9, 99.9
MINIMUMS FOR TOTAL LIST REPORTING    BILLED  99999     PROVIDERS  99999   CLAIMS   99999    SERVICES  99999

                                  -----TRENDS-----  -REFERENCE PERIOD-    MMM YY    MMM YY    MMM YY    MMM YY    MMM YY
----------ACTIVITY SUMMARY----------      PEER    INDIV  WEIGHT PER GP AVG    MMM YY    MMM YY    MMM YY    MMM YY    MMM YY
01-Amount Billed                        X999.99  X999.99  99,999  99,999.99  999999.99  999999.99  999999.99  999999.99  999999.99 X
02-Amount Paid                          X999.99  X999.99  99,999  99,999.99  999999.99  999999.99  999999.99  999999.99  999999.99 X
03-Percent Paid of Billed               X999.99  X999.99  99,999  99,999.99  999999.99  999999.99  999999.99  999999.99  999999.99 X
04-Number of Claims                     X999.99  X999.99  99,999  99,999.99  999999.99  999999.99  999999.99  999999.99  999999.99 X
05-Number of Recipients                 X999.99  X999.99  99,999  99,999.99  999999.99  999999.99  999999.99  999999.99  999999.99 X
06-Avg Amt Billed/Recipient             X999.99  X999.99  99,999  99,999.99  999999.99  999999.99  999999.99  999999.99  999999.99 X
07-Avg Amt Paid/Recipient               X999.99  X999.99  99,999  99,999.99  999999.99  999999.99  999999.99  999999.99  999999.99 X

TOTAL EXCEPTIONS         999,999                                                  99,999     99,999     99,999     99,999     99,999
TOTAL WEIGHT             999,999                                              99,999,999 99,999,999 99,999,999 99,999,999 99,999,999

FYTD TOTALS TITLE XIX     NO SVCS   9999  AMT BILLED 999,999.99    AMT ALLOWED  999,999.99  AMT PAID 999,999.99  PCT PAID/BILLED 999.99
            TITLE XVIII             9999             999,999.99                 999,999.99           999,999.99                  999.99
```

Report Definition: SUR-3520-Q Selected Recipient Summary Profile

Part I Report Definition Information

Functional Area: SURS

Report Number: SUR-3520-Q

Job Name: DSIBMU34

Report Title: Selected Recipient Summary Profile

Description of Information

The Selected Recipient Summary Profile Report gives the user the option of selecting recipients for which a summary profile is produced regardless of whether or not the recipient had exceptions. The activity minimums are not applied to selected recipients. The format of this report is exactly like that of the Recipient Exception Summary Profile Report.

Purpose of Report

A Selected Recipient Summary Profile Report may be requested to ensure that a Profile will be produced for recipients who are targeted for review from sources other than the Exception Ranking Report.

Sort Sequence

Recipient peer group, recipient number

Distribution

Distribution	Media	Copies	Frequency
EDS	CRLD		Quarterly, on request
IFSSA	CRLD		Quarterly, on request

Selected Recipient Summary Profile

Part II Report Definition Information

Functional Area: SURS

Report Number: SUR-3520-Q

Detailed Field Definitions

The report field descriptions for the Selected Recipient Summary Profile Report are identical to those of the Recipient Summary Profile (Exceptions) Report. Please refer to the report field descriptions section for Recipient Exception Summary Profile Report for this information.

Report Example: Selected Recipient Summary Profile

```
  REPORT:  SUR-3520- Q                                INDIANAIM                                                PAGE NUM: 99,999
 PROCESS:  DSIBMU34                                                                                           RUN DATE: 05/08/99
LOCATION:  HUGS352B                  SELECTED RECIPIENT SUMMARY PROFILE REPORT                               RUN TIME: 14:37:56

REPORT SEQUENCE - A                                                                                 PERIOD:   MM YY THRU MM YY

REPORT—LOCATION – L45 - Lake                 AID CATEGORY – AGED – AGED RECIPIENTS                LTC – N/A   AGE 999  SEX  XXX

RACE N/A SPEC PR N/A
DETAIL—LOCATION – 45  - Lake                 AID CATEGORY – A    – AGED MEDICAID                  LTC   N     AGE 999  SEX  XXX

RACE 2   SPEC PR

RID  999999999999   NAME BROWN        CHRISTINE                              CASE NUMBER  9999999999 DOB - MM/DD/CCYY

START DATE - MM/DD/CCYY  RACE 2

REFERENCE PERIOD:  MMM YY-MMM YY    FYTD PERIOD -  MMM YY-MMM YY  REFERENCE PERIOD PEER GROUP COUNT -      99,999    TOT WGT -  999,999

PERIOD WEIGHT MULTIPLIERS: 99.9, 99.9, 99.9, 99.9, 99.9

MINIMUMS FOR EXCEPTION REPORTING    BILLED  99999     PROVIDERS  99999   CLAIMS   99999    SERVICES  99999

                                    -----TRENDS----- -REFERENCE PERIOD-    MMM YY    MMM YY    MMM YY    MMM YY    MMM YY
----------ACTIVITY SUMMARY----------      PEER    INDIV  WEIGHT PER GP AVG    MMM YY    MMM YY    MMM YY    MMM YY    MMM YY

01-Amount Billed                       X999.99  X999.99  99,999  99,999.99  999999.99  999999.99  999999.99  999999.99  999999.99 X
02-Amount Paid                         X999.99  X999.99  99,999  99,999.99  999999.99  999999.99  999999.99  999999.99  999999.99 X
03-Percent Paid of Billed              X999.99  X999.99  99,999  99,999.99  999999.99  999999.99  999999.99  999999.99  999999.99 X
04-Number of Claims                    X999.99  X999.99  99,999  99,999.99  999999.99  999999.99  999999.99  999999.99  999999.99 X
05-Number of Recipients                X999.99  X999.99  99,999  99,999.99  999999.99  999999.99  999999.99  999999.99  999999.99 X
06-Avg Amt Billed/Recipient            X999.99  X999.99  99,999  99,999.99  999999.99  999999.99  999999.99  999999.99  999999.99 X
07-Avg Amt Paid/Recipient              X999.99  X999.99  99,999  99,999.99  999999.99  999999.99  999999.99  999999.99  999999.99 X

TOTAL EXCEPTIONS         999,999                                                 99,999     99,999     99,999     99,999     99,999
TOTAL WEIGHT             999,999                                              99,999,999 99,999,999 99,999,999 99,999,999 99,999,999

FYTD TOTALS TITLE XIX     NO SVCS   9999  AMT BILLED 999,999.99    AMT ALLOWED  999,999.99  AMT PAID 999,999.99  PCT PAID/BILLED 999.99
            TITLE XVIII             9999             999,999.99                 999,999.99           999,999.99                  999.99
```

Report Definition: SUR-3540-Q Recipient Exception Deselection

Part I Report Definition Information

Functional Area:	SURS
Report Number:	SUR-3540-Q
Job Name:	DSIBMU34
Report Title:	Recipient Exception Deselection Report

Description of Information

The Recipient Summary Deselection Listing Report is produced when the user has created a list of recipients that are to be eliminated from exception processing. If a recipient is deselected, that recipient's activity is included in the peer group summaries (355) and a summary profile (351) is produced. However, these recipients are not eligible for the exception profiles (350) or the summary exception rank report (360). The deselected recipient, deselect date, and comments are input by the user into the Provider/Recipient Deselection Input Window.

Purpose of Report

The Recipient Summary Deselection Listing Report provides a reference for the user on recipients not included in exception processing.

Sort Sequence

Recipient number

Distribution

Distribution	Media	Copies	Frequency
EDS	Hardcopy	One copy	Quarterly
IFSSA	Hardcopy	One copy	Quarterly

Recipient Exception Deselection

Part II Report Definition Information

Functional Area: SURS

Report Number: SUR-3540-Q

Detailed Field Definitions

Table 6.25 – Field Description

Field	Description
Period	The time frame reflected by the data on the report.
RID	The deselected recipient's number (user input on the Deselection File).
Review Date	A user specified date, for informational purposes only, usually identifying the date of previous review. In Indiana, recipients are deselected for one year following a review of their utilization, then are removed from the deselection listing to allow exception processing rank reporting if aberrant utilization patterns exists. Restricted recipients are also deselected for the period of restriction.
Review Status & Comments	The user gives a brief reason the recipient is deselected, such as current program restriction, on review or managed care monitored (user input on the Deselection File).
Total Recipients Deselected	The total number of recipients who are on the deselection file.

Report Example: Recipient Exception Deselection

```
  REPORT:  SUR-3540- Q                                INDIANAIM
 PROCESS:  DSIBMU34                                                                                  PAGE NUM: 99,999
LOCATION:  HUGS354B                   RECIPIENT SUMMARY DESELECTION LISTING REPORT                   RUN DATE: 05/08/99
                                                                                                     RUN TIME: 14:37:56

                                                                                             PERIOD:    MM YY THRU MM YY

         RID                         REVIEW DATE             REVIEW STATUS AND COMMENTS

      999999999999                  MMDDCCYY                XX

      999999999999                  MMDDCCYY                XX

      999999999999                  MMDDCCYY                XX

      999999999999                  MMDDCCYY                XX

      999999999999                  MMDDCCYY                XX


                                       TOTAL RECIPIENT DESELECTED 9,999
```

Report Definition: SUR-3550-Q Recipient Peer Group Summary Profile

Part I Report Definition Information

Functional Area:	SURS
Report Number:	SUR-3550-Q
Job Name:	DSIBMU34
Report Title:	Recipient Peer Group Summary Profile

Description of Information

The Recipient Peer Group Summary Profile Report is a statistical summary by peer group for all user-defined parameters. From the data accumulated on the report, peer group averages are calculated and trends are computed to be compared to the individual's activity.

Purpose of Report

The Recipient Peer Group Summary Profile Report can be used to assess the cost and type of medical care received by each recipient peer group, to measure the effectiveness of, or the need for, major program changes, or to analyze the medical activity of selected recipient aid categories and peer classifications.

Sort Sequence

Report sequence, peer group

Distribution

Distribution	Media	Copies	Frequency
EDS	CRLD		Quarterly
IFSSA	CRLD		Quarterly

Recipient Peer Group Summary Profile

Part II Report Definition Information

Functional Area: SURS

Report Number: SUR-3550-Q

Detailed Field Definitions

Table 6.26 Field Description

Field	Description
Report Sequence	The report sequence code.
Period	The time frame reflected by the data on the report.
Report Location	The peer group location code and description.
Aid Category	The peer group aid category code and description.
LTC	A 'Y' in the field indicates that the peer group is comprised of long term care recipients.
Age	The group code for age assigned to this peer group when the age option is used.
Sex	The sex code for this peer group when the sex option is used: F = female, M = male and B = both.
Race	The race code for this peer group when the race option is used.
Spec Pr	The special program code for this peer group when the special program option is used.
Reference Period	The reporting period selected by the user as the period on which peer group averages are to be computed for comparison to the recipient's activity for determination of exceptions. P1 is the most recent period. Currently set at 2
FYTD Period	The fiscal year-to-date period which defines data to be included in the FYTD totals at the bottom of the report. The user determines the month to be used for the fiscal year-to-date accumulations. The dates displayed in this field begin with the first month of the fiscal year and end with the last month of data being reported. Currently July
Ref Period Peer Grp Count	The total number of recipients in the peer group who have data in the reference period, and whose activity is used to compute the peer group averages.
[Reporting Period Headers]	The month(s) and year(s) for beginning and ending dates for reporting periods 1 through 5.
Activity Summary	A list of user-defined report elements which apply to the report image in which the recipient has activity. Exception limits established by the user for each parameter appear immediately following the line item to which it pertains. Up to 99 line items can be selected by the user according to current needs. Within the recipient category of service, nine different sets of line items are available. The ninth set is considered the 'default' activity summary and applies to all recipients in the category of service whose peer specifications are not specified elsewhere.
Line Item Number	The line item number as defined on the 40 control file.
Line Item Description	The line item description as defined on the 40 control file.

Table 6.26 Field Description

Field	Description
Trend	A measure of the change in totals over the five reporting periods for the peer group. TREND = $\frac{100 \text{ X } (2P1 + P2 - P4 - 2P5)}{2 \text{ X } (P1 + P2 + P3 + P4 + P5)}$ P1 represents the most recent reporting period, P2 represents the next most recent reporting period, etc. If less than five periods are reported, the value of unused periods is zero, therefore; the result of the trend calculation may not be valid. The Trends field can be suppressed, if the user determines this information is of little value and/or may be misleading.
Line Item Values [Periods 1-5]	The computed values for individual reporting periods (1-5) for each line item.

Table 6.27 – FYTD Totals (Title XIX and XVIII)

Field	Description
Svcs	Total number of services received by this peer group for the Title XIX and XVIII payment classes.
Billed	Total dollars billed for services received by this peer group for the Title XIX and XVIII payment classes.
Allowed	Total dollars allowed for services received by this peer group for the Title XIX and XVIII payment classes.
Paid	Total dollars paid for services received by this peer group for the Title XIX and XVIII payment classes.
Pct/Pd/Bill	Percentage of the amount billed that was paid for services in the Title XIX and XVIII payment classes.

Report Example: Recipient Peer Group Summary Profile

```
  REPORT:  SUR-3550- Q                              INDIANAIM
 PROCESS:  DSIBMU31
LOCATION:  HUGS355B                    RECIPIENT PEER GROUP SUMMARY PROFILE REPORT                    PAGE NUM: 99,999
                                                                                                      RUN DATE: 05/08/99
                                                                                                      RUN TIME: 14:37:56

REPORT SEQUENCE - A                                                                  PERIOD:   MM YY THRU MM YY

REPORT—LOCATION – L10 - Allen              AID CATEGORY – AGED – AGED RECIPIENTS          LTC – N/A   AGE 999  SEX  XXX

RACE N/A SPEC PR N/A

          REFERENCE PERIOD  MMM YY-MMM YY    FYTD PERIOD -  MMM YY-MMM YY  REFERENCE PERIOD PEER GROUP COUNT -      99,999

                                                    MMM YY       MMM YY       MMM YY       MMM YY       MMM YY
----------ACTIVITY SUMMARY----------       TREND     MMM YY       MMM YY       MMM YY       MMM YY       MMM YY

NUMBER OF PROVIDERS REPORTING                        9,999.99     9,999.99     9,999.99     9,999.99     9,999.99
NUMBER OF DIFFERENT PATIENTS                         9,999.99     9,999.99     9,999.99     9,999.99     9,999.99

  01-Amount Billed                       - 999.99  9,999,999.99 9,999,999.99 9,999,999.99 9,999,999.99 9,999,999.99
  02-Amount Paid                         - 999.99  9,999,999.99 9,999,999.99 9,999,999.99 9,999,999.99 9,999,999.99
  03-Percent Paid of Billed              - 999.99  9,999,999.99 9,999,999.99 9,999,999.99 9,999,999.99 9,999,999.99
  04-Number of Claims                    - 999.99  9,999,999.99 9,999,999.99 9,999,999.99 9,999,999.99 9,999,999.99
  05-Number of Recipients                + 999.99  9,999,999.99 9,999,999.99 9,999,999.99 9,999,999.99 9,999,999.99
  06-Avg Amt Billed/Recipient            + 999.99  9,999,999.99 9,999,999.99 9,999,999.99 9,999,999.99 9,999,999.99
  07-Avg Amt Paid/Recipient              + 999.99  9,999,999.99 9,999,999.99 9,999,999.99 9,999,999.99 9,999,999.99


FYTD TOTALS TITLE XIX       SVCS   9999      BILLED 999,999.99       ALLOWED  999,999.99      PAID 999,999.99  PCT/PAID/BILLED 999.99
            TITLE XVIII            9999             999,999.99                999,999.99           999,999.99                  999.99
```

Report Definition: SUR-3560-Q Recipient Summary Profile Exceptions Statistics

Part I Report Definition Information

Functional Area:	SURS
Report Number:	SUR-3560-Q
Job Name:	DSIBMU34
Report Title:	Recipient Summary Profile Exceptions Statistics

Description of Information

The Recipient Summary Profile Exceptions Statistics Report displays the statistical information related to each line item on the summary profiles. Two report pages of information are produced for each peer group.

Purpose of Report

With the data from the Recipient Summary Profile Exceptions Statistics Report, the user can analyze each line item for effectiveness and determine if the exception limits are too high or too low. The user can determine the appropriateness of line items and exception limits by analyzing the number and percent of exception recipients for each line.

Ideally, the user wants approximately only the top 5% of recipients in a peer group to except on a line. This percentage may vary depending on the size of the peer group, the nature of the line item, and several other factors. Before the exception limits on any line are adjusted, the user should appraise all peer group averages reported in the reporting image, the standard deviations of each, the number of recipients in each, and the intended use of the information from the line item.

If a certain line item consistently has no exceptions across all peer groups, the user should evaluate the need for the line item, and replace it with one more likely to reveal aberrant activity.

Sort Sequence

Report sequence, peer group

Distribution

Distribution	Media	Copies	Frequency
EDS	CRLD		Quarterly
IFSSA	CRLD		Quarterly

Recipient Summary Profile Exception Statistics

Part II Report Definition Information

Functional Area: SURS

Report Number: SUR-3560-Q

Detailed Field Definitions

Table 6.28 – Field Description

Field	Description
Report Sequence	The report sequence code.
Period	The time frame reflected by the data on the report.
Location	The peer group locality code and description.
Aid Category	The peer group aid category code and description.
LTC	A 'Y' in the field indicates that the peer group is comprised of long term care recipients.
Age	The group code for age assigned to this peer group when the age option is used.
Sex	The sex code for this peer group when the sex option is used F = female, M = male and B = both.
Race	The race code for this peer group when the race option is used.
Spec Pr	The special program code for this peer group when the special program option is used.
Reference Period	The reporting period selected by the user as the period on which peer group averages are to be computed for comparison to the recipient's activity for determination of exceptions. P1 is the most recent period. Currently set at 2.
Ref Period Peer Grp Count	The total number of recipients in the peer group who have data in the reference period, and whose activity is used to compute the peer group averages.
Exception Counts for Period Ending [Period Dates, 1-5]	The ending date of the summary reporting periods 1-5.
Activity Summary	A list of user-defined report elements which apply to the report image being reported.
[Line Item Number]	The line item number as defined on the 40 control file.
[Line Item Description]	The line item description as defined on the 40 control file.

Table 6.28 – Field Description

Field	Description
Reference Period Average	The peer group average for each line item based on the reference period activity.
Reference Period Low Limit	The value of the low limit established by the user. If the limit is a percentage or standard deviation variance, the minimum allowable calculated from the peer group average appears in this field.
Reference Period High Limit	The value of the high limit established by the user. If the limit is a percentage or standard deviation variance, the maximum allowable value calculated from the peer group average appears in this field.
Lo Exception Count	The total number of low exceptions during each period.
Hi Exception Count	The total number of high exceptions during each period.
Reference Period:	
Average	The average value for the peer group for the line item.
Std Dev	The value of one standard deviation for the peer group. Asterisks indicate there is not more than one recipient with activity for the line.
Max Value	The highest value that occurred for any individual within the peer group during the reference period.
Exceptions % of Per Gp	The percent of recipients in the peer group who excepted on the line during the reference period.
All Periods-Total Exceptions	The total number of exceptions for the line during all period reported.

Report Example: Recipient Summary Profile Exception Statistics

```
  REPORT:  SUR-3560- Q                                   INDIANAIM
 PROCESS:  DSIBMU34
LOCATION:  HUGS356B              RECIPIENT SUMMARY PROFILE EXCEPTIONS STATISTICS REPORT                    PAGE NUM: 99,999
                                                                                                          RUN DATE: 05/08/99
                                                                                                          RUN TIME: 14:37:56

REPORT SEQUENCE - A                                                                          PERIOD:   MM YY THRU MM YY

REPORT—LOCATION – L10 - Allen             AID CATEGORY – AGED – AGED RECIPIENTS                  LTC – N/A   AGE 999  SEX  XXX

RACE N/A SPEC PR N/A

          REFERENCE PERIOD  MMM YY-MMM YY                                  REFERENCE PERIOD PEER GROUP COUNT -      99,999

                                    ---------REFERENCE PERIOD--------- ------------EXCEPTION COUNTS FOR PERIOD ENDING-------------
                                                ----LOW---- ----HIGH---     MMM YY      MMM YY      MMM YY      MMM YY       MMM YY
----------ACTIVITY SUMMARY---------- --AVERAGE-    LIMIT       LIMIT       LO    HI    LO    HI    LO    HI    LO    HI     LO   HI


NUMBER OF RECIPIENTS REPORTING

01-Amount Billed                       9999.99    +9999.99    9999.99     99    99    99    99    99    99    99     99  99    99
02-Amount Paid                         9999.99    +9999.99    9999.99     99    99    99    99    99    99    99     99  99    99
03-Percent Paid of Billed              9999.99    +9999.99    9999.99     99    99    99    99    99    99    99     99  99    99
04-Number of Claims                    9999.99    +9999.99    9999.99     99    99    99    99    99    99    99     99  99    99
05-Number of Recipients                9999.99    +9999.99    9999.99     99    99    99    99    99    99    99     99  99    99



                                    ------------------------REFERENCE  PERIOD-----------------------       -ALL PERIODS-

----------ACTIVITY SUMMARY---------- --AVERAGE-      --STD. DEV.-      --MAX VALUE-      --EXCEPTIONS-        ----TOTAL---

                                                                                        -% OF PER GP-        -EXCEPTIONS-
99 XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX   9999999.99      999999999.99      999999999.99         999.99           999999999
```

Report Definition: SUR-3570-Q Recipient Summary Profile (Forced) Exception

Part I Report Definition Information

Functional Area: SURS

Report Number: SUR-3570-Q

Job Name: DSIBMU34

Report Title: Recipient Summary Profile (Forced) Exception

Description of Information

The Recipient Summary Profile (Forced) Exception Report provides the user with a report that is identical in format to the Recipient Summary Profile (350) report. It contains a summary profile for any recipient who has excepted on a line item which the user designates as a forced exception line item. The exception limit should be defined carefully in the 40 Control File in order to produce the report on only the most deviant recipients; otherwise, the volume of paper produced could be unmanageable.

Purpose of Report

The user can request a Recipient Summary Profile (Forced) Exception Report to support areas of special study.

Sort Sequence

Recipient peer group, recipient number

Distribution

Distribution	Media	Copies	Frequency
EDS	CRLD		Quarterly, on request
IFSSA	CRLD		Quarterly, on request

Recipient Summary Profile (Forced) Exception

Part II Report Definition Information

Functional Area: SURS

Report Number: SUR-3570-Q

Detailed Field Definitions

The report field descriptions for the Recipient Summary Profile (Forced) Exception Report are identical to those of the Recipient Summary Profile (Exception) Report. Please refer to the report field descriptions section for Recipient Summary Profile (Exception) Report for this information.

Report Example: Recipient Summary Profile (Forced) Exception

```
  REPORT:  SUR-3570- Q                                INDIANAIM                                          PAGE NUM: 99,999
 PROCESS:  DSIBMU34                                                                                     RUN DATE: 05/08/99
LOCATION:  HUGS357B                  RECIPIENT SUMMARY PROFILE REPORT (FORCED)                         RUN TIME: 14:37:56

REPORT SEQUENCE - A                                                                          PERIOD:   MM YY THRU MM YY

REPORT—LOCATION – L02 - Allen                  AID CATEGORY – AGED – AGED RECIPIENTS                LTC – N/A   AGE 999  SEX  XXX

RACE N/A SPEC PR N/A
DETAIL—LOCATION – 02  - Allen                  AID CATEGORY – A    – AGED MEDICAID                  LTC   N     AGE 999  SEX  XXX

RACE 2   SPEC PR

RID  999999999999   NAME BROWN        CHRISTINE                              CASE NUMBER  9999999999 BIRTH - MM/DD/CCYY

START DATE - MM/DD/CCYY  RACE 2

REFERENCE PERIOD:  MMM YY-MMM YY    FYTD PERIOD -  MMM YY-MMM YY  REFERENCE PERIOD PEER GROUP COUNT -      99,999    TOT WGT -  999,999

PERIOD WEIGHT MULTIPLIERS: 99.9, 99.9, 99.9, 99.9, 99.9

                                  -----TRENDS----- -REFERENCE PERIOD-    MMM YY    MMM YY    MMM YY    MMM YY    MMM YY
----------ACTIVITY SUMMARY----------      PEER    INDIV  WEIGHT PER GP AVG    MMM YY    MMM YY    MMM YY    MMM YY    MMM YY

01-Amount Billed                     X999.99  X999.99  99,999  99,999.99  999999.99  999999.99  999999.99  999999.99  999999.99 X
02-Amount Paid                       X999.99  X999.99  99,999  99,999.99  999999.99  999999.99  999999.99  999999.99  999999.99 X
03-Percent Paid of Billed            X999.99  X999.99  99,999  99,999.99  999999.99  999999.99  999999.99  999999.99  999999.99 X
04-Number of Claims                  X999.99  X999.99  99,999  99,999.99  999999.99  999999.99  999999.99  999999.99  999999.99 X
05-Number of Recipients              X999.99  X999.99  99,999  99,999.99  999999.99  999999.99  999999.99  999999.99  999999.99 X
06-Avg Amt Billed/Recipient          X999.99  X999.99  99,999  99,999.99  999999.99  999999.99  999999.99  999999.99  999999.99 X
07-Avg Amt Paid/Recipient            X999.99  X999.99  99,999  99,999.99  999999.99  999999.99  999999.99  999999.99  999999.99 X

TOTAL EXCEPTIONS         999,999                                              99,999     99,999     99,999     99,999     99,999
TOTAL WEIGHT             999,999                                          99,999,999 99,999,999 99,999,999 99,999,999 99,999,999

FYTD TOTALS TITLE XIX     NO SVCS   9999  AMT BILLED 999,999.99    AMT ALLOWED  999,999.99  AMT PAID 999,999.99  PCT PAID/BILLED 999.99
            TITLE XVIII             9999             999,999.99                 999,999.99           999,999.99                  999.99
```

Report Definition: SUR-3600-Q Recipient Summary Profile Exception Ranking

Part I Report Definition Information

Functional Area:	SURS
Report Number:	SUR-3600-Q
Job Name:	DSIBMU34
Report Title:	Recipient Summary Profile Exception Ranking

Description of Information

The Recipient Summary Profile Exception Ranking Report lists the exception recipients in descending weight order. The weight is an accumulation of the weight assigned to each exception item the recipient has on his summary profile.

Purpose of Report

The Recipient Summary Profile Exception Ranking Report is the first report used in selecting recipients for review. The reference period volume totals assist the reviewer in selecting recipients who are receiving substantial services under the program.

Once a recipient is selected from the ranking report, that recipient's summary profile is reviewed to determine if further investigation is appropriate.

Sort Sequence

Exception weight

Distribution

Distribution	Media	Copies	Frequency
EDS	CRLD		Quarterly
IFSSA	CRLD		Quarterly

Recipient Summary Profile Exception Ranking

Part II Report Definition Information

Functional Area: SURS

Report Number: SUR-3600-Q

Detailed Field Definitions

Table 6.29 Field Description

Field	Description
Category of Service	The category of service code and description.
Report Sequence	This field displays the report sequence within category of service when the multiple report sequence option is used.
Reference Period	The reporting period selected by the user as the period on which peer group averages are to be computed for comparison to the recipient's activity for determination of exceptions. P1 is the most recent period. Currently set to 2.
Period Weight Multipliers	A factor selected by the user by which the computed exception weight is multiplied for each corresponding reporting period. This enables the user to effect higher weight on exception items in a selected reporting period such as the reference period, and lower weight in periods where the data may not be as complete due to the claim filing deadline. This factor is a whole number and one decimal place. There are five period weight multipliers.
Reporting Limit	The maximum number of recipients to be ranked as specified by the user. Default value is 1000. Currently set to 500.
Minimums for Exception Reporting [Providers, 1, Services, 6, Claims, 6, Charges, 900.]	User selected activity minimums that must be met before a recipient is considered an exception recipient. Minimum values for charges, providers, claims, and services can be established by the user to ensure that low volume recipients are not considered exceptions. Low volume recipients receive high exception weight because their averages and percentages are distorted simply because they receive very few services. By setting these minimums at realistic levels, the exception reports produced are more likely to represent valid cases of abuse or misutilization. The values set apply to the recipient's activity during the reference period.
Report Aid Category	The aid category code and description.
Rank	The relative rank of the recipient among all recipients reported. (Rank of 1 is assigned to the recipient with the highest weight whose activity volume is equal to or greater than the minimums).
Totl Weight	The exception weight from the recipient's summary profile which determines rank. Recipients can be ranked by their exception weight from any one of the reporting periods or by total weight of all periods. The weight source is displayed in the report header. 'TOTL' means the total weight from all reporting periods is used for ranking. 'Per 1' means the exception weight from the most current reporting period is used.
Tot Exp	The total number of exceptions the recipient has for all reporting periods.
RID	The recipient's medical identification number.
Name	The recipient's name - last, first, and middle initial.
Loc	The recipient's peer group locality code.
Aid	The recipient's peer group aid category code.

Table 6.29 Field Description

Field	Description
L	The recipient's long term care code.
A	The recipient's age.
S	The recipient's sex.

Table 6.30 – Reference Reporting Period Amounts:

Field	Description
No Svcs	The total number of services received during the reference period based on either dates of service or date of payment.
Billed	The total dollar amount billed for the recipient during the reference period based on either dates of service or date of payment.
Allowed	The total dollar amount allowed during the reference period based on either dates of service or date of payment.
Paid	The total dollar amount paid for the recipient during the reference period based on either dates of service or date of payment.
No Prv	The total number of providers from whom the recipient has received services during the reference period based on either dates of service or date of payment.
No Clm	The total number of claims submitted by the recipient during the reference period based on either dates of service or date of payment.
SUR-3500 Page No	The page number of the exception profile (350) for this recipient.

Report Example: Recipient Summary Profile Exception Ranking

```
  REPORT:  SUR-3600- Q                                INDIANAIM                                                    PAGE NUM: 99,999
 PROCESS:  DSIBMU31                                                                                               RUN DATE: 05/08/99
LOCATION:  HUGS360B              RECIPIENT SUMMARY PROFILE EXCEPTION RANKING REPORT                               RUN TIME: 14:37:56

                  REFERENCE PERIOD:  MMM YY-MMM YY     PERIOD WEIGHT MULTIPLIERS: 99.9, 99.9, 99.9, 99.9, 99.9

REPORTING LIMIT -  99999    MINIMUM PROVIDERS -   99999   MINIMUM SERVICES -  99999   MINIMUM CLAIMS -   99999  MINIMUM CHARGES - 99999

REPORT-- AID CATEGORY –  AGED RECIPIENTS
                                                                                  --------------REFERENCE REPORTING PERIOD--------------
       TOTL  TOT ------------------------RECIPIENT-------------------------     NO. ----------- AMOUNTS ------------ NO.  NO.  SUR-350
RANK  WEIGHT EXP  RID              NAME                        LOC  AID  L  A  S SVCS  BILLED     ALLOWED     PAID     PRV  CLM  PAGE NO

 141   19283   8  999999999999     FORDICE     CHARLES         L40  A    Y  99 M    3  99999.99   99999.99    99999.99   9    9      999

 142   19283   8  999999999999     SMITH       TIM             L40  A    Y  99 M    3  99999.99   99999.99    99999.99   9    9      999

 143   19283   8  999999999999     JONES       BOB             L40  A    Y  99 M    3  99999.99   99999.99    99999.99   9    9      999

 144   19283   8  999999999999     MINOR       BRIAN           L40  A    Y  99 M    3  99999.99   99999.99    99999.99   9    9      999

 145   19283   8  999999999999     GULLETTE    CHEVERIA        L40  A    Y  99 F    3  99999.99   99999.99    99999.99   9    9      999
```

Report Definition: SUR-1600-D Selected Recipient Detail History

Part 1 Report Definition Information

Functional Area: SURS

Report Number: SUR-1600-D

Job Name: DSIBMU16

Report Title: Selected Recipient Detail History

Description of Information

The selected Recipient Detail History Report displays claim data for selected recipients. Information such as date of service, procedure, diagnosis, provider, and lock-in segment data is reported. Recipients selected for report production are keyed into a TSO member monthly, with a date of service range specified for each recipient entry.

Purpose of Report

The Selected Recipient Detail History Report provides the user with a detailed history of Medicaid services utilization. The recipient's episode of illness, drug utilization, and overall Medicaid utilization patterns can be analyzed, with recommendation of appropriate corrective action for Program abusers.

Sort Sequence

Within recipient:

Claim type P, all claim types, and Date of Service.

Distribution

Distribution	Media	Copies	Frequency
EDS	Paper	1 copy	On request
IFSSA	Paper	1 copy	On request

Selected Recipient Detail History

Part II Report Definition Information

Functional Area: SURS

Report Number: SUR-1600-D

Detailed Field Definitions

Table 6.31 – Field Description

Field	Description
Report Number	The report number assigned to this routinely processed report.
Process	The process number assigned to the program process.
Location	The system location
Run Date	The date the report was processed in mm/dd/yy format.
Run Time	The time the report was processed in HH:MM:SS format.
Page	The page number of the report produced for the recipient. Page sequencing resets to 1 at each new recipient.
Period	The period reported, as selected by the user.

Table 6.32 – Header Information

Field	Description
RID	The recipient Medicaid identification number, as carried on the Recipient Base.
Name	The recipient name in Last, First, M.I. order, as carried on the Recipient Base.
Address	The recipient address as carried on the Recipient Base.
Cty Code	The recipient county code as carried on the Recipient Base.
Birthdate	The recipient date of birth as carried on the Recipient Base.
PMP Assignment Info	Primary medical provider (managed care) information will display if the recipient has been active in the managed care program during the 15 months of history carried on the master file. As indicated by a PMP segment End Date > the first date of the 15 month master file period.
Provider	The 10 digit Medicaid identification number of the recipient's primary care manager (PCCM) as carried on the recipient Base, PMP Assignment History Window. Blanks will appear if no PCCM is associated within the recipient.
MCO	The 9 digit Medicaid identification number of the managed care organization within which the recipient is enrolled as carried on the Recipient Base, PMP Assignment History Window. Blanks will appear if no MCO is associated with the recipient.
Group	The 9 digit Medicaid identification number of the group to which the PMP belongs as carried on the Recipient Base, PMP Assignment Hisory Window. Blanks will appear if no group is associated with the recipient.
Start	The start date of the PMP assignment.
End	The end date of the PMP assignment.
Lock In Providers	The provider numbers to whom the recipient is locked in at a time of report production. The Provider ID End Date on the Recipient Providers Per Restriction Period Window must equal to 2299/12/31 for the provider to be reported.

Table 6.33 – Detail Information

Field	Description
ICN	The internal control number of the claim.
DOS/Disp Date From-To	For claim type P, the dispense date from the drug claim record is reported in both the from and to fields. For all other claim types, the from and to dates of service from the claim details are reported.
POS	Place of Service code from the claim record.
Proc/Proc Identification Code/NDC/Rev	For claim type P, the national drug code from the claim record. For claim type I and L, the revenue code (if no corresponding HCPC code is available) from the claim record. For all other claim types, the procedure code, or procedure identification code, from the claim record.
Desc	The narrative description for each procedure, NDC or revenue code reported.
MODIFIED DESC	The description of the procedure/modifier/taxonomy combination that is associated with the procedure identification code.
Modifiers	Modifiers 1-4 associated with the procedure from the claim record.
Units/Qnty	the number of units or quantity from the claim record.
Days Sply	For claim type P, the days supply as carried on the claim record.
Billed	The billed amount from the claim detail record.
Allowed	The allowed amount from the claim detail record.
Paid Dt	The date of payment from the claim record.
Provider	For claim type P, the prescribing physician from the claim record. For claim type I, the attending provider from the claim record. For all other claim types, the rendering (or performing) provider from the claim record.
Typ	The provider type of the Rend/Prsc provider reported, as carried on the provider table.
Spc	The primary provider specialty of the Rend/Prsc provider reported, as carried on the provider table.
Diagnosis	Diagnosis 1-4 from the claim record.
Description	The narrative description for each diagnosis code reported, as carried on the Diagnosis Reference Table.
Disch Stat	For claim type I and L, the patient discharge status code from the claim record.
Disch/Presc	For claim type I and L, the date of discharge from the claim record. For claim type P, the prescribed date from the claim record.
Days Stay	For claim I and L, the discharge date minus admit date.
DRG	For claims paid according to diagnosis related grouping payment methodology, The DRG code assigned by the Grouper program for the claim.
Description	The narrative description for the DRG code.
DRG Paid	The amount paid for the claim paid according to DRG pricing methodology.
Billing Provider	The billing provider's number form the claim record.
Last Name	The billing provider's last name, as carried on the Provider table.

Table 6.33 – Detail Information

Field	Description
Typ	The billing provider's type code, as carried on the provider table.
Spc	The billing provider's primary specialty code, as carried on the provider table.

Table 6.34 – Claim Type Totals

Field	Description
CT	The claim type being reported.
Providers	The number of providers who submitted claims for the claim type during the period reported.
Services	Total number of services for the claim type during the period reported.
Billed	Total billed amount for the claim type during the period reported.
Allowed	Total allowed amount for the claim type during the period reported.
Claims	Total number of claims for the claim type during the period reported.

Table 6.35 – Grand Totals

Field	Description
Providers	Total number of providers who submitted claims during the period reported.
Services	Total number of services for the period reported.
Amt Billed	Total billed amount for the period reported.
Amt Allowed	Total allowed amount for the period reported.
Claims	Total number of claims for the period reported.

Report Example: Selected Recipient Detail History

```
REPORT:    SUR-1600- D                                  INDIANAAIM                                  PAGE NUM:       6
PROCESS:   srgjd280                              PERIOD: 01012001-09302003                         RUN DATE:  09/16/2003
LOCATION:  SRGP1602                        SELECTED RECIPIENT DETAIL HISTORY                       RUN TIME:  17:23:57

RID: XXXXXXXXXXXX XXXXXXXXXX    XXXXXX        XXX X XXXXX XX             XXXXX XXXXXX       XX XXXXX CTY CDE: XX BIRTHDATE: XXXXXXXX

PMP ASSIGNMENT INFORMATION:    PROVIDER:              MCO:           GROUP:                  START:            END:
LOCK-IN PROVIDERS:  XXXXXXXXX XXXXXXXXX XXXXXXXXX XXXXXXXXX

 ICN           DOS/DISP DATE    POS PROC/NDC/REV                              UNITS/QTY  DAYS      BILLED       ALLOWED    PAID DT
                 FROM-TO                                                                 SPLY   CLM PAID  CHECK NO.    PROVIDER  TYP SPC

XXXXXXXXXXXX  XXXXXXXX XXXXXXXX 11  L8040                                      1.00     0      1500.00       1225.49    09192003
                  PROC DESC   NASAL PROSTHESIS, PROVIDED BY A NON-PHYSICIAN              1225.49  999999999    XXXXXXXXX 031 344
                  MODIFIED DESC                                                      MOD KM
DIAGNOSES: (1) 25003 DIABETES MELLITUS WI (2)                        (3)                          (4)

XXXXXXXXXXXX  XXXXXXXX XXXXXXXX 11  80069      8091AW                            1.00     0        25.00         25.00    09192003
                  PROC DESC   RENAL FUNCTION PANEL                                    25.00  999999999    XXXXXXXXX 031 344
                  MODIFIED DESC   TESTING FOR SUR PRICING MODIFIERS                 MOD
DIAGNOSES: (1) 25003 DIABETES MELLITUS WI (2)                        (3)                          (4)

XXXXXXXXXXXX  XXXXXXXX XXXXXXXX 11  92506      TT                                1.00     0        45.00         45.00    09192003
                  PROC DESC   3RD MEDICAL EVALUATION SPEECH, LANGUAGE AND/OR HE       45.00  999999999    XXXXXXXXX 031 344
                  MODIFIED DESC   TEST NOT A VALID CODE                            MOD
DIAGNOSES: (1) 25003 DIABETES MELLITUS WI (2)                        (3)                          (4)

XXXXXXXXXXXX  XXXXXXX XXXXXXXX 11  M0064                                     1.00     0        45.00         15.74    09192003
                  PROC DESC   BRIEF OFFICE VISIT FOR  SOLE PURPOSE OF MONITORIN       15.74  999999999    XXXXXXXXX 031 344
                  MODIFIED DESC   TESTING PROCEDURE NOT VALID                      MOD
DIAGNOSES: (1) 25003 DIABETES MELLITUS WI (2)                        (3)                          (4)

CLAIM TYPE TOTALS:        CT         PROVIDERS         SERVICES       BILLED         ALLOWED           CLAIMS

                          M             1                 4          1615.00         1311.23              4

GRAND TOTALS:                           1                 4          1615.00         1311.23              4
```

Provider Treatment Analysis Reporting

The Provider Treatment Analysis Reports are dependent on the peer group treatment models and procedure norms established in the Phase II Treatment Criteria and Norms Generation Reports. The Provider Treatment Analysis Reports differ from the Summary Profiles by focusing on procedure utilization in diagnosis treatment rather than volume analysis. A total picture of the provider's practice is displayed on the Provider Treatment Analysis Reports and unique aspects of each provider's procedure utilization are identified.

Reports produced are:

1. Treatment Analysis Reports
   - Provider Treatment Analysis (Exceptions) Report
   - Provider Treatment Analysis (Total List) Report
   - Provider Treatment Analysis (Selected) Report
2. Treatment Analysis Ranking Reports
   - Treatment Analysis Exception Ranking (Diagnosis) Report
   - Provider Treatment Analysis Exception Ranking Report

The Provider Treatment Analysis Reports (exceptions, total list and selected) present a statistical profile of treatment rendered by individual physicians in response to specific diagnoses. The reports are intended to detect inappropriate utilization of services in the treatment of specified diagnoses thereby revealing deficiencies or excesses in the level and quality of care being delivered to Medical Assistance recipients.

Criteria weight is assigned to 'required' procedure categories which the provider underutilizes and to 'never' procedures which the provider overutilizes. Utilization weight is assigned to detail and cross-reference procedure codes when the provider's utilization rate has exceeded the community's high norm for number of services per 100 patients. If the provider's utilization ratio is less than the low norm, utilization weight will also be assigned.

In a provider case review, those diagnosis/procedure combinations which receive the highest weights are singled out as priority targets for review. Line items which flagged on the Provider Summary Profile (320) report can be researched at this level. Since all procedures used by a provider are reported on the Treatment Analysis Report, misutilization not revealed on the Summary Profile is detected. The Treatment Analysis Reports identify the specific diagnoses and procedures or procedure categories the provider is misutilizing. Deficiency in the quality of care is also indicated by the provider's non-performance of 'required' procedures.

Once these problem areas are identified, the specific cases can be investigated through claim details. If it is determined that there are actual abuses, several optional methods exist to correct the situation, through the detail level study, including prepayment audits, provider education, field investigations, recoupment, etc. Once corrective action is instigated, the Treatment Analysis Reports can be used to monitor the subsequent activity of the provider.

The Provider Treatment Analysis Reports (rankings) identify those providers who have deviated most significantly from the peer group treatment models and/or utilization norms. The suggested method for using the reports is to first select high ranking providers who have a substantial volume of practice. The list of providers selected for review from the ranking reports are compared to the list selected for review from the Provider Summary Profile Exception Ranking. Those providers appearing on both lists become the priority cases for further review.

Report Definition: SUR-4300-Q Provider Treatment Analysis (Exceptions)

Part I Report Definition Information

Functional Area:	SURS
Report Number:	SUR-4300-Q
Job Name:	DSIBMU40
Report Title:	Provider Treatment Analysis (Exceptions)

Description of Information

The Provider Treatment Analysis (Exceptions) Report displays an individual exception provider's profile of procedures used in the treatment of specific diagnoses. The provider's utilization of procedures is compared to that of the provider community's performance. This report emphasizes diagnosis treatment patterns rather than volume analysis.

Purpose of Report

The Provider Treatment Analysis (Exceptions) Report can be used to identify unique aspects of each provider's procedure utilization in relation to medical diagnoses.

Sort Sequence

Provider peer group, provider number, cross-reference diagnosis code

Distribution

Distribution	Media	Copies	Frequency
EDS	CRLD		Quarterly
IFSSA	CRLD		Quarterly

Provider Treatment Analysis (Exceptions)

Part II Report Definition Information

Functional Area: SURS

Report Number: SUR-4300-Q

Detailed Field Definitions

Table 6.36 – Probabilities

Field	Description
Required Bounds	The range of criteria probabilities that defines a 'required' service. The user-defined percentage value which determines 'required' procedures can be changed from that used on the 290 report at the time 430, 431, and 432 reports are generated.
Not Required Bounds	The range of criteria probabilities that defines a 'not required' service. The user-defined percentage value which determines 'never' procedures can be changed from that used on the 290 report at the time 430, 431, and 432 reports are generated.
Utilization is Based on	This field identifies the statistical base for the peer group from/to range. This field contains 'NORMS' (mean plus and minus 'X' number of standard deviations) from 270 or 'PERCENTILES' as determined on the 271.
Report Locality	The provider's peer group locality code and description.
Type	The provider's peer group type code and description.
Specialty	The provider's peer group specialty code and description.
Detail Locality	The provider's original locality code and description.
Type	The detail type code and description.
Specialty	The detail specialty code and description.
Provider	The provider's medical identification number, name, and address.
UR Flag	Not used in Indiana
HBP	Not used in Indiana
Group	This field indicates whether or not the provider is a group provider ('G' = group provider, 'I' = individual)
Diagnosis	The cross-reference diagnosis code and description.
Age	The recipient age group being reported if the user applies this option.
Recipient Count	The number of recipients treated by the provider in the diagnosis category being reported.
Number of Services	The total number of services performed by this provider for the diagnosis.
Total Charges	The total value of dollars billed by this provider for treatment of this diagnosis.
Procedure Code	The procedure code (detail or cross-reference). Cross-reference codes appear on the first line of the group. Information for the cross-reference code reflects totals for all detail codes in the group.

Table 6.36 – Probabilities

Field	Description
Rcpt Rec	The number of recipients who received services for this procedure code from this provider.
No Svcs	The total number of services for the procedure code within the diagnosis category performed by this provider.

Table 6.37 – Criteria:

Field	Description
Cnd	This field indicates what the peer group practice determines to be the requirement level for this service. (REQ, OPT, NEV, or NOT). NOT indicates that at the time the treatment model file is built, the peer group did not have any activity on which to compute a criteria condition.)
Pcnt Proc - Peer	The percent of recipients in the diagnosis category who received services for the procedure from the peer group.
Pcnt Proc - Indiv	The percent of recipients in the diagnosis category who received this procedure from the provider being reported.
Weight	The weight assigned to the procedure for the provider. Weight is calculated only on the cross reference code level and only if the provider's utilization is an exception: i.e., the peer group criteria is required or not required and the provider's practice is outside of the bounds allowed. The formula for calculating criteria weight is as follows: • If a procedure falls within the 'required' category and there is no recipient of service in the type service/procedure category for the provider, criteria weight is computed as follows: CRITERIA WT = 10 X UPPER BOUND CRITERIA • If the provider percent for a 'never' procedure is greater than criteria lower bound, criteria weight is calculated as follows: CRIT WT = (PROV PCT - CLB) X (10 X # RECIPS) CRITERIA LOWER BOUND EXAMPLE: (17.14 – 10.00) X (10 X 6) = 42 10.00 • If the provider percent for a 'required' procedure category is less than criteria upper bound, the criteria weight is calculated as follows: CRIT WT = (CUB – PROV PCT) X (10 X # RECIPS) CRITERIA UPPER BOUND EXAMPLE: (90.00 –57.50) X (10 X 31) = 111 90.00 The number of recipients used in these computations is the total for the cross-reference value because criteria weight is assigned only for the procedure category and not for the detail codes. The criteria weights are rounded off. No criteria weight is assigned to 'optional' procedures regardless of a provider's utilization due to the peer group determining it as a procedure that may or may not occur.

Table 6.38 – Utilization:

Field	Description
Peer Norm Range Low / High	These figures define the acceptable limits of norms for this service. The figures are based on services per 100 recipients in the diagnosis category.
Indiv	The provider's utilization ratio of number of services per 100 recipients for this procedure.
Weight	The weight assigned to this provider for deviation outside of the high/low range of norms. Utilization weight is rounded. The formula for utilization weight is as follows: • If the peer group norms are zero: UTILIZATION WT = PROV RATIO X # SVCS / 100 EXAMPLE: 51.43 X 18 = 9 / 100 • If the provider exceeds the peer group high norm: UTILIZATION WEIGHT = (PROV RATIO - HIGH NORM) X (10 X # SVCS) / HIGH NORM EXAMPLE: (50.00 - 16.10) X (10 X12) = 253 / 16.10 • If the provider's ratio is less than the low norm: UTILIZATION WEIGHT = (LOW NORM - PROV RATIO) X (10 X NUM SVCS) / LOW NORM • If the provider ratio is less than or equal to the norm: UTILIZATION WT = 0
Avg Svc Peer	The average number of services per recipient provided by the peer group. This number is computed on the 270 report.
Avg Svc Indiv	The average number of services per recipient performed by this provider.

Table 6.39 – Charges:

Field	Description
Avg/Proc Peer	The average amount billed per service by the peer group for the procedure. This figure is computed on the SUR-0270-Q report.
Avg/Proc Indiv	The average amount billed per service for the procedure by the provider.
Total	The total amount billed by this provider for the procedure in treatment of this diagnosis category.
(Proc Description)	The description of the procedure codes reported by this provider during the reporting period.

Table 6.40 – Totals:

Field	Description
Recipients	The total number of recipients reported for this provider.
Xrf Diagnoses	The total number of cross-reference diagnoses reported for this provider.
Xrf Procedures	The total number of cross-reference procedures reported for this provider.
Services	The total number of services billed by this provider.
Charges	The total amount billed by this provider.

Table 6.41 – Weights:

Field	Description
Diagnosis - Criteria	The total criteria weight assigned to this provider.
Utilization	The total utilization weight assigned to this provider.
Total	The total of both utilization and criteria weights for this provider.

Report Example: Provider Treatment Analysis (Exceptions)

```
REPORT:   SUR-4300- Q                                    INDIANAAIM                                          PAGE           1
PROCESS:  DSIBMU40                                    PERIOD:  MM/YY THRU MM/YY                              RUN DATE: 09/29/00
LOCATION: HUGP430B                          PROVIDER TREATMENT ANALYSIS REPORT (EXCEPTIONS)                  RUN TIME: 23:26:57

PROBABILITIES --- REQUIRED BOUNDS -  90.00-100.00 NOT REQUIRED BOUNDS -  0.00-10.00         UTILIZATION IS BASED ON NORMS

REPORT-LOCALITY – 00S  - Out of State          TYPE – T31 - Physician                      SPECIALTY – S315 – EMERGENCY MEDICINE

DETAIL-LOCALITY – 94   - IFSSA (Border city)   TYPE – 031 - Physician                      SPECIALTY – 315 - EMERGENCY MEDICINE PRACT

PROVIDER -  999999999    NAIL & SMITH PSC         4010   DUPONT  #345    LOUISVILLE             IN  23482  UR FLAG      HBP N  GROUP N

DIAGNOSIS -  XV000 -  MEDICAL AND SPECIAL EXAMS************************************

RECIPIENT COUNT -     9999      NUMBER OF SERVICES -  999,999    TOTAL CHARGES -  9,999,999.99

                            --------CRITERIA---------  -----------UTILIZATION----------                  ---------CHARGES---------
PROCEDURE         RCPT     NO       --PCNT PROC--          -PEER NORM RANGE-                    ---AVG SVC---    --AVG/PROC---
CODE              RECV    SVCS  CND   PEER  INDIV  WEIGHT     LOW      HIGH    INDIV   WEIGHT    PEER  INDIV    PEER  INDIV     TOTAL


X1080                2     43  NOT    0.00 100.00    180    0.00      0.00  2150.00      925    0.00  21.50     0.00  6.49      279.00
      ALLERGY / SPEC DIAGNOSES PROC ******************************
  95115              0      3         0.00   0.00           0.00      0.00     0.00             0.00   0.00     0.00  0.00       14.00
      PROF. SER FOR ALL. IMM NOT INCLUDING PROVISION OF ALLE
  95165              0     41         0.00   0.00           0.00      0.00     0.00             0.00   0.00     0.00  0.00      265.00


**TOTALS**   RECIPIENTS -      1    XRF DIAGMOSES     -   1  XRF PROCEDURES -      1    SERVICES -        1    CHARGES -       265.00

                     WEIGHTS---DIAGNOSIS  - CRITERIA -        0    UTILIZATION -        1    TOTAL -        1
```

Report Definition: SUR-4310-Q Provider Treatment Analysis (Total List)

Part I Report Definition Information

Functional Area:	SURS
Report Number:	SUR-4310-Q
Job Name:	DSIBMU40
Report Title:	Provider Treatment Analysis (Total List)

Description of Information

The Provider Treatment Analysis (Total List) Report displays every individual provider's profile of procedures used in the treatment of specific diagnoses. The provider's utilization of procedures is compared to that of the provider community's performance. This report emphasizes diagnosis treatment patterns rather than volume analysis and identifies unique aspects of each provider's procedure utilization in relation to medical diagnoses.

Purpose of Report

The Provider Treatment Analysis (Total List) Report can be used to identify unique aspects of any provider's procedure vs. diagnosis utilization, regardless of exceptional activity.

Sort Sequence

Provider peer group, provider number, cross-reference diagnosis code

Distribution

Distribution	Media	Copies	Frequency
EDS	CRLD		Quarterly
IFSSA	CRLD		Quarterly

Provider Treatment Analysis (Total List)

Part II Report Definition Information

Functional Area:	SURS
Report Number:	SUR-4310-Q

Detailed Field Definitions

The report field descriptions for the Provider Treatment Analysis (Total List) Report are identical to those of the Provider Treatment Analysis (Exceptions) Report. Please refer to the report field descriptions section for Provider Treatment Analysis (Exceptions) Report for this information.

Report Example: Provider Treatment Analysis (Total List)

```
REPORT:   SUR-4310- Q                                    INDIANAAIM                                                PAGE           1
PROCESS:  DSIBMU40                                  PERIOD:  MM/YY THRU MM/YY                                      RUN DATE: 09/29/00
LOCATION: HUGP430B                          PROVIDER TREATMENT ANALYSIS REPORT (TOTAL LIST)                         RUN TIME: 23:26:57

PROBABILITIES --- REQUIRED BOUNDS -  90.00-100.00 NOT REQUIRED BOUNDS -  0.00-10.00          UTILIZATION IS BASED ON NORMS

REPORT-LOCALITY – 00S  - Out of State           TYPE – T31 - Physician                      SPECIALTY – S315 – EMERGENCY MEDICINE

DETAIL-LOCALITY – 94   - IFSSA (Border city)    TYPE – 031 - Physician                      SPECIALTY – 315 - EMERGENCY MEDICINE PRACT

PROVIDER -  999999999    NAIL & SMITH PSC         4010   DUPONT  #345    LOUISVILLE              IN  23482  UR FLAG      HBP N  GROUP N

DIAGNOSIS -  XV000 -  MEDICAL AND SPECIAL EXAMS************************************

RECIPIENT COUNT -     9999      NUMBER OF SERVICES -  999,999    TOTAL CHARGES -  9,999,999.99

                            --------CRITERIA---------  -----------UTILIZATION----------                  ---------CHARGES---------
PROCEDURE         RCPT     NO       --PCNT PROC--          -PEER NORM RANGE-                    ---AVG SVC---   --AVG/PROC---
CODE              RECV    SVCS  CND   PEER  INDIV  WEIGHT     LOW      HIGH    INDIV   WEIGHT    PEER  INDIV    PEER  INDIV     TOTAL


X1080                2     43  NOT    0.00 100.00    180    0.00      0.00  2150.00      925    0.00  21.50     0.00  6.49      279.00
      ALLERGY / SPEC DIAGNOSES PROC ******************************
  95115              0      3         0.00   0.00           0.00      0.00     0.00             0.00   0.00     0.00  0.00       14.00
      PROF. SER FOR ALL. IMM NOT INCLUDING PROVISION OF ALLE
  95165              0     41         0.00   0.00           0.00      0.00     0.00             0.00   0.00     0.00  0.00      265.00


**TOTALS**   RECIPIENTS -      1    XRF DIAGMOSES      -   1  XRF PROCEDURES -      1    SERVICES -        1    CHARGES -       265.00

                     WEIGHTS---DIAGNOSIS  - CRITERIA -        0    UTILIZATION -        1    TOTAL -        1
```

Report Definition: SUR-4320-Q Provider Treatment Analysis (Selected)

Part I Report Definition Information

Functional Area:	SURS
Report Number:	SUR-4320-Q
Job Name:	DSIBMU40
Report Title:	Provider Treatment Analysis (Selected)

Description of Information

The Provider Treatment Analysis (Selected) Report displays user-selected provider profiles of procedures used in the treatment of specific diagnoses. The provider's utilization of procedures is compared to that of the provider community's performance. This report emphasizes diagnosis treatment patterns rather than volume analysis and identifies unique aspects of each provider's procedure utilization in relation to medical diagnoses.

Purpose of Report

The Provider Treatment Analysis (Selected) Report can be used to identify unique aspects of a selected provider's procedure vs. diagnosis utilization, in the same manner as the Exceptions and Total List Reports.

Sort Sequence

Provider peer group, provider number, cross-reference diagnosis code

Distribution

Distribution	Media	Copies	Frequency
EDS	CRLD		Quarterly, On Request
IFSSA	CRLD		Quarterly, On Request

Provider Treatment Analysis (Selected)

Part II Report Definition Information

Functional Area:	SURS
Report Number:	SUR-4320-Q

Detailed Field Definitions

The report field descriptions for the Provider Treatment Analysis (Selected) Report are identical to those of the Provider Treatment Analysis (Exceptions) Report. Please refer to the report field descriptions section for Provider Treatment Analysis (Exceptions) Report for this information.

Report Example: Provider Treatment Analysis (Selected)

```
REPORT:   SUR-4320- Q                                    INDIANAAIM                                          PAGE           1
PROCESS:  DSIBMU40                                  PERIOD:  MM/YY THRU MM/YY                                RUN DATE: 09/29/00
LOCATION: HUGP430B                          SELECTED PROVIDER TREATMENT ANALYSIS REPORT                       RUN TIME: 23:26:57

PROBABILITIES --- REQUIRED BOUNDS -  90.00-100.00 NOT REQUIRED BOUNDS -  0.00-10.00         UTILIZATION IS BASED ON NORMS

REPORT-LOCALITY – IN  - INDIANA           TYPE – T31 - Physician                     SPECIALTY – S335 – PEDIATRICIAN

DETAIL-LOCALITY – 49  - Marion            TYPE – 031 - Physician                     SPECIALTY – 335  - PEDIATRICIAN

PROVIDER -  999999999    NAIL & SMITH PSC         4010   DUPONT  #345    LOUISVILLE             IN  23482  UR FLAG      HBP N  GROUP N

DIAGNOSIS -  XV000 -  MEDICAL AND SPECIAL EXAMS**************************************

RECIPIENT COUNT -     9999      NUMBER OF SERVICES -  999,999    TOTAL CHARGES -  9,999,999.99

                           --------CRITERIA---------  -----------UTILIZATION----------                  ---------CHARGES---------
PROCEDURE         RCPT     NO       --PCNT PROC--          -PEER NORM RANGE-                    ---AVG SVC---    --AVG/PROC---
CODE              RECV    SVCS  CND   PEER  INDIV  WEIGHT     LOW      HIGH    INDIV   WEIGHT    PEER  INDIV    PEER  INDIV     TOTAL


X1080                2     43  NOT    0.00 100.00    180    0.00      0.00  2150.00      925    0.00  21.50     0.00  6.49      279.00
      ALLERGY / SPEC DIAGNOSES PROC ******************************
  95115              0      3         0.00   0.00           0.00      0.00     0.00             0.00   0.00     0.00  0.00       14.00
      PROF. SER FOR ALL. IMM NOT INCLUDING PROVISION OF ALLE
  95165              0     41         0.00   0.00           0.00      0.00     0.00             0.00   0.00     0.00  0.00      265.00


**TOTALS**   RECIPIENTS -      1    XRF DIAGMOSES      -   1  XRF PROCEDURES -      1    SERVICES -        1    CHARGES -       265.00

                     WEIGHTS---DIAGNOSIS  - CRITERIA -        0    UTILIZATION -        1    TOTAL -        1
```

Report Definition: SUR-4330-Q Treatment Analysis Exception Ranking (Diagnosis)

Part I Report Definition Information

Functional Area:	SURS
Report Number:	SUR-4330-Q
Job Name:	DSIBMU40
Report Title:	Treatment Analysis Exception Ranking (Diagnosis)

Description of Information

The Treatment Analysis Exception Ranking (Diagnosis) Report ranks providers based on exceptions from treatment models and/or norms (as identified on the Treatment Analysis Reports). The criteria weight, utilization weight, or the total of both weights can be used as the ranking weight. In addition to weight and rank, certain information is shown which indicates the provider's volume of practice as an aid to the reviewer in selecting cases. Minimum levels of activity are established which a provider must reach before being ranked on the report. This criteria prevents low-volume providers from ranking artificially high.

Purpose of Report

The Treatment Analysis Exception Ranking Reports can be used in combination with the Provider Summary Ranking Report to select provider cases for review.

Sort Sequence

Weight - one of the three weights (utilization, criteria, total)

The report can be produced in up to six different sequences in any quarterly run. The user can specify up to three levels of sort options using any three or less of the following. Different weight fields can be specified for each.

- Peer Group Locality
- Peer Group Type
- Peer Group Specialty
- None selected

Distribution

Distribution	Media	Copies	Frequency
EDS	CRLD		Quarterly
IFSSA	CRLD		Quarterly

Treatment Analysis Exception Ranking (Diagnosis)

Part II Report Definition Information

Functional Area: SURS

Report Number: SUR-4330-Q

Detailed Field Definitions

Table 6.42 Field Description

Field	Description
Weight Field	The selected weight field for ranking. 'Total' indicates both the criteria and utilization weights used.
Rpt Limit	The maximum number of providers to be ranked as defined on the 10 control file.
Min Rec	The minimum number of recipients a provider must treat before that provider is ranked as defined on the 10 control file.
Min Svc	The minimum number of services that a provider must perform before that provider is ranked as defined on the 10 control file.
Min Diag	The minimum number of cross reference diagnoses that a provider assigns before that provider is ranked as defined on the 10 control file.
Min Proc	The minimum number of different cross reference type service/procedures a provider must perform before that provider is ranked as defined on the 10 control file.
Min Chg	The minimum dollars a provider must bill before that provider is ranked as defined on the 10 control file.
Rank	The relative rank of this provider based on selected weight. This field is always blank when the report is produced in provider number sequence.
Weight	The provider's criteria, utilization, or total weight as selected by the user for ranking.
Number	The Medical Assistance identification number of the provider.
Name	The provider's name.
Loc	The provider's cross reference locality code.
Typ	The provider's cross reference type code.
Spc	The provider's cross reference specialty code.
No Rcpt	The number of recipients treated by this provider.

Table 6.42 Field Description

Field	Description
No Diag	The number of different cross reference diagnosis codes assigned by this provider.
No Proc	The number of different cross reference procedure codes used by this provider.
No Svcs	The number of services performed by this provider.
Total Charges	The total amount billed for services performed by this provider.
Criteria Weight	The total criteria weight for this provider based on treatment model exceptions identified on 431.
Utilization Weight	The total utilization weight for this provider based on exception from the peer group norms identified on 431.
Weight Total	The sum of criteria and utilization weights for this provider.

Report Example: Treatment Analysis Exception Ranking (Diagnosis)

```
REPORT:   SUR-4330  Q                                   INDIANAAIM                                              PAGE           1
PROCESS:  DSIBMU40                                PERIOD:  MM/YY THRU MM/YY                                     RUN DATE: 09/29/00
LOCATION: HUGP430B                  TREATMENT ANALYSIS EXCEPTION RANKING REPORT (DIAGNOSIS)                     RUN TIME: 23:26:57

WEIGHT FIELD - UTIL   RPT LIMIT -    500  MIN REC -      1  MIN SVC -      1  MIN DIAG -      1  MIN PROC -      1  MIN CHRG -    100

               ---------PROVIDER----------------------------------          NO      NO     NO    NO       TOTAL   ---------WEIGHT--------
  RANK     WEIGHT    NUMBER       NAME                       LOC  TYP  SPC     RCPT    DIAG   PROC  SVCS   CHARGES       CRIT    UTIL   TOTAL

    76     187425    999999999    MEMORIAL CLINIC OF INDIA   IN   T31  S315      67       2     16  2790     4,456        234  324044  324564

    77     185678    999999999    MEMORIAL HOSPITAL          IN   T31  S311       7       6      3  3456    11,636       6758  324564  324564

    78     434567    999999999    KLEIN                      L99  T99  S999     267      10      1  2534     1,400       1111  124455  889564

    79     167890    999999999    CLINIC OF INDIANA          IN   T31  S315       4       7     76  1098     2,300      66756  112454  324564

    80     178667    999999999    KOCHERT                    IN   T31  S315      57       2     78   987    98,000        567  897654  324564
```

Report Definition: SUR-4350-Q Provider Treatment Analysis Exception Ranking

Part I Report Definition Information

Functional Area:	SURS
Report Number:	SUR-4350-Q
Job Name:	DSIBMU40
Report Title:	Provider Treatment Analysis Exception Ranking

Description of Information

The Provider Treatment Analysis Exception Ranking Report ranks providers based on exception weight assigned to exceptional diagnosis treatment and activity from treatment models and/or norms. The criteria weight, utilization weight, or total of both weights can be used as the ranking weight. In addition to his weight and rank, information is displayed which indicates the provider's volume of practice as an aid in selecting cases. Minimum levels of activity are established which a provider must reach before being ranked on the report. This prevents low-volume providers from being artificially reported.

Purpose of Report

This report is produced in provider number sequence and provides a cross reference to the Treatment Analysis Exception (Diagnosis) Ranking report.

Sort Sequence

Provider number (ascending)

Distribution

Distribution	Media	Copies	Frequency
EDS	CRLD		Quarterly
IFSSA	CRLD		Quarterly

Provider Treatment Analysis Exception Ranking

Part II Report Definition Information

Functional Area:	SURS
Report Number:	SUR-4350-Q

Detailed Field Definitions

The report field descriptions for the Provider Treatment Analysis Exception Ranking Report are identical to those of the Treatment Analysis Exception Ranking (Diagnosis) Report. Please refer to the report field descriptions section for Treatment Analysis Exception Ranking (Diagnosis) Report for this information.

Report Example: Provider Treatment Analysis Exception Ranking

```
REPORT:   SUR-4350  Q                                  INDIANAAIM                                                  PAGE           1
PROCESS:  DSIBMU40                                PERIOD:  MM/YY THRU MM/YY                                       RUN DATE: 09/29/00
LOCATION: HUGP430B                      PROVIDER TREATMENT ANALYSIS EXCEPTION REPORT                               RUN TIME: 23:26:57


WEIGHT FIELD - UTIL   RPT LIMIT -    500  MIN REC -      1  MIN SVC -      1  MIN DIAG -      1  MIN PROC -      1  MIN CHRG -    100

               ---------PROVIDER-------------------                 NO      NO     NO    NO       TOTAL   ---------WEIGHT--------
 NUMBER       NAME                       LOC  TYP  SPC  RANK    WEIGHT RCPT    DIAG   PROC  SVCS   CHARGES       CRIT    UTIL   TOTAL

 999999999    MEMORIAL CLINIC OF INDIA   IN   T31  S315  276    187425   62      12     10   790    44,456        234  324044  324564

 999999999    MEMORIAL HOSPITAL          IN   T31  S311   45    187425    7      34      6    90     5,673       1222  124455  889564

 999999999    KLEIN                      IN   L99  T99  S999    187425   34      56      4  1234     9,234       9283  124455  889564

 999999999    CLINIC OF INDIANA          IN   T31  S315  345    187425   56      89      7  3845    78,345       2345  324044  324564

 999999999    KOCHERT                    IN   T31  S315  987    187425   78     345     11  2556    12,345        208  897654  324564
```

Hospital DRG Reporting

The DRG reports were developed by EDS for use in Medicaid program administration to effectively monitor and manage the utilization of program funds under a diagnosis related grouping (DRG) reimbursement system.

Length of stay continues to be a major indicator in evaluating quality of inpatient care. With the one-fee-for-all methodology of DRGs, potential problem areas include unusually short stays, premature discharges, and/or inappropriate admissions/transfers. The DRG reporting identifies these areas, and assigns weight and ranks hospitals whose length of stay (high or low) varies significantly from their peers.

The DRG focus is based mainly on underutilization rather than over utilization. The objectives are:

- Identify the hospitals and physicians responsible for length of stay exceptions, both high and low.
- Provide extensive support data when exception activity is identified.
- Analyze comparison data of charges billed by specific hospitals to peer group and statewide activity for major ancillary groupings.
- Provide an analysis of pre and post hospitalization services, identifying duplication of services and outpatient cost shifting.

Reports produced are:

- DRG Length of Stay Ranking
- Length of Stay by Diagnosis Category and Admitting Physician
- DRG Length of Stay Detail
- Ancillary Distribution
- Merged History
- Physician Length of Stay Exception

Report Definition: SUR-0551-Q DRG Length of Stay Ranking

Part I Report Definition Information

Functional Area:	SURS
Report Number:	SUR-0551-Q
Job Name:	DSIBMUD6
Report Title:	DRG Length of Stay Ranking

Description of Information

The DRG Length of Stay Ranking Report lists the exception hospitals in descending weight order. The weight is an accumulation of the weight assigned to each deviation from the DRG mean length of stay on the Length of Stay Detail Report. Basic hospital information and a brief summary of each hospital's activity is displayed. Page reference is given to the 553 Detail Report.

Purpose of Report

The DRG Length of Stay Ranking Report can be used to identify the top hospitals whose length of stay patterns deviate most significantly from that of their peers. A more specific review of the overall case activity that caused the exceptions and rank can then be pursued through use of the Length of Stay Detail Report.

Sort Sequence

Three sorts are produced:

1. High Exception Weight
2. Low Exception Weight
3. Hospital Number

Distribution

Distribution	Media	Copies	Frequency
EDS	CRLD		Quarterly
IFSSA	CRLD		Quarterly

DRG Length of Stay Ranking

Part II Report Definition Information

Functional Area: SURS

Report Number: SUR-0551-Q

Detailed Field Definitions

Table 6.43 – Field Description

Field		Description
Period		The time frame reflected by the data on the report.
Exception:	Rank	Relative rank of hospital among all hospitals reported. Rank of 1 is assigned to hospital with the highest "HI" weight.
	HI	The total number of "HI" exceptions the hospital had.
	Weight	"HI" exception weight from the hospital's detail report, which determines rank.
	Rank	Relative rank of hospital among all hospitals reported. Rank of 1 is assigned to hospital with the highest "LO" weight.
	LO	The total number of "LO" exceptions the hospital had.
	Weight	"LO" exception weight from the hospital's detail report, which determines rank.
Hospital		Hospital provider number.
Name		Hospital name.
Claims		The number of claims submitted for the reporting period.
Amount Billed		The amount billed, calculated from the claim details.
Amount Paid		The amount paid, calculated from the header (DRG paid amount).
553		Page number of the 553 Detail Report for this hospital.

Report Example: DRG Length of Stay Ranking

```
  REPORT:   SUR-0551-Q                              INDIANA AIM                                        DATE: 10/23/00
 PROCESS:   DSIBMUD6                  DRG LENGTH OF STAY RANKING BY HIGH WEIGHT                       TIME: 14:01:33
LOCATION:   HUGP551B                          PERIOD: MM/YY THRU MM/YY                               PAGE:       1
```

----------EXCEPTION----------									AMOUNT	AMOUNT	SUR0553Q
RANK	HI	WEIGHT	RANK	LO	WEIGHT	HOSPITAL	NAME	CLAIMS	BILLED	PAID	PAGE
001	004	47534	033	051	3155	999999999	ST ANTHONY HOSPITAL-	336	24,707,733.15	4,456,234.00	200
002	004	47534	033	051	3155	999999999	ST ANTHONY HOSPITAL-	336	24,707,733.15	4,456,234.00	200
003	004	47534	033	051	3155	999999999	ST ANTHONY HOSPITAL-	336	24,707,733.15	4,456,234.00	200
004	004	47534	033	051	3155	999999999	ST ANTHONY HOSPITAL-	336	24,707,733.15	4,456,234.00	200
005	004	47534	033	051	3155	999999999	ST ANTHONY HOSPITAL-	336	24,707,733.15	4,456,234.00	200
006	004	47534	033	051	3155	999999999	ST ANTHONY HOSPITAL-	336	24,707,733.15	4,456,234.00	200
007	004	47534	033	051	3155	999999999	ST ANTHONY HOSPITAL-	336	24,707,733.15	4,456,234.00	200
008	004	47534	033	051	3155	999999999	ST ANTHONY HOSPITAL-	336	24,707,733.15	4,456,234.00	200
009	004	47534	033	051	3155	999999999	ST ANTHONY HOSPITAL-	336	24,707,733.15	4,456,234.00	200
010	004	47534	033	051	3155	999999999	ST ANTHONY HOSPITAL-	336	24,707,733.15	4,456,234.00	200
001	004	47534	033	051	3155	999999999	ST ANTHONY HOSPITAL-	336	24,707,733.15	4,456,234.00	200

Report Definition: SUR-0552-Q DRG Length of Stay by Diagnosis Category and Admitting Physician

Part I Report Definition Information

Functional Area:	SURS
Report Number:	SUR-0552-Q
Job Name:	DSIBMUD6
Report Title:	Length of Stay by Diagnosis Category and Admitting Physician

Description of Information

The Length of Stay by Diagnosis Category and Admitting Physician Report provides a comprehensive summary of hospital activity by diagnostic category. DRG codes are assigned categorically and combined data is reported by individual hospital, by peer group and statewide.

The top 10 admitting physicians for the hospital during the reporting period are also displayed.

Purpose of Report

The Length of Stay by Diagnosis Category and Admitting Physician Report can be used to evaluate the hospital's length of stay patterns by diagnostic category and compare the individual hospital's activity to that of it's peers and to the rest of the state.

This report is also especially useful in identifying which admitting physicians may be responsible for exceptional lengths of stay or high utilization of inpatient services.

Sort Sequence

Peer group, hospital number

Distribution

Distribution	Media	Copies	Frequency
EDS	CRLD		Quarterly
IFSSA	CRLD		Quarterly

Length of Stay by Diagnostic Category and Admitting Physician

Part II Report Definition Information

Functional Area: SURS

Report Number: SUR-0552-Q

Detailed Field Definitions

Table 6.44 – field Description

Field	Description
Period	The time frame reflected by the data on the report.

Table 6.45 – Diagnosis Category Section:

Field	Description
Hospital	Hospital provider number.
City	The hospital's city.
Peer Group	Reporting hospital's peer group code and description.
Number Discharges	Number of discharges (claims with patient status other than "30") for each diagnostic category and totals.
Total Days	Total number of inpatient days calculated as follows: Total Days = Discharge Date - Admit Date
Avg LOS	Average length of stay calculated as follows: Avg LOS = Total Days # Discharges
Admitting Physicians	The number of different admitting physicians during the reporting period.
Dollars Billed	The total amount billed, calculated from the claim details.
Dollars Paid	The total amount paid, calculated from the claim header (DRG amount paid).
Avg Paid	The average amount paid calculated as follows: Avg Paid = Dollars Paid # Discharges

Table 6.46 – Admitting Physician Section:

Field	Description
Rank	The rank sequence of admitting physicians by number of admits.

Table 6.46 – Admitting Physician Section:

Field	Description
Number	The provider number of the admitting physician.
Name	Name of admitting physician.
Specialty	Reporting specialty of admitting physician.
Admits	Total number of admissions by this physician for this hospital during the reporting period.

Report Example: DRG Length of Stay by Diagnosis Category and Admitting Physician

```
  REPORT:   SUR-0552-Q                              INDIANA AIM                                                DATE: 10/23/00
 PROCESS:   DSIBMUD6            LENGTH OF STAY BY DIAGNOSIS CATEGORY AND ADMITTING PHYSICIAN                  TIME: 14:01:33
LOCATION:   HUGP552B                          PERIOD: MM/YY THRU MM/YY                                       PAGE:       1

HOSPTIAL    999999999        AUDUBON REGIONAL MED CTR-   CITY LOULSVILLE          PEER GROUP S10    ACUTE CARE HOSPITAL

                              NUMBER          TOTAL          AVG       ADMITTING      DOLLARS        DOLLLARS          AVERAGE
                            DISCHARGES         DAYS          LOS      PHYSICIANS      BILLED           PAID              PAID
MEDICAL  DX / DRG                  7            73         10.4              0       205,514.86       63,135.55         9,019.36

SURGICAL  DX / DRG                 7            73         10.4              0       205,514.86       63,135.55         9,019.36

OBSTETRICAL  DX / DRG              7            73         10.4              0       205,514.86       63,135.55         9,019.36

NEWBORN  DX / DRG                  7            73         10.4              0       205,514.86       63,135.55         9,019.36

PSYCHIATRIC  DX / DRG              7            73         10.4              0       205,514.86       63,135.55         9,019.36

OTHER DRG                          7            73         10.4              0       205,514.86       63,135.55         9,019.36

         ***************************************************************************************************************
HOSPITAL TOTAL                    33           540         16.3              2     1,200,234.00     3,456,234.56        12,123.34

PEER GROUP TOTAL                1234         23456          1.3           1234    123,234,234.23     1.373.835.64         3,234.45

STATEWIDE TOTAL                 1234         23456          1.3           1234    123,234,234.23     1.373.835.64         3,234.45

                  ***************************************************************************
                  *                                                                         *
                  *                                                                         *
                  *                            ADMITTING PHYSICIAN RANK                     *
                  *                                                                         *
                  *        RANK            NUMBER             NAME           SPECIALTY   ADMITS  *
                  *                                                                         *
                  *         01           999999999       PEDIATRIC-NEONA         345          1  *
                  *         02           999999999       DRESZER                 335          1  *
                  *                                                                         *
```

Report Definition: SUR-0553-Q DRG Length of Stay Detail

Part I Report Definition Information

Functional Area:	SURS
Report Number:	SUR-0553-Q
Job Name:	DSIBMUD6
Report Title:	DRG Length of Stay Detail

Description of Information

The DRG Length of Stay Detail Report displays DRG frequency data and summary information for each hospital. Exceptions are noted and exception weight is accrued.

Purpose of Report

The DRG Length of Stay Detail Report provides the user with detail information regarding which DRGs are contributing to the provider's exceptions, causing the provider to rank on the DRG Length of Stay Ranking Report.

Sort Sequence

Peer group, hospital number

Distribution

Distribution	Media	Copies	Frequency
EDS	CRLD		Quarterly
IFSSA	CRLD		Quarterly

DRG Length of Stay Detail

Part II Report Definition Information

Functional Area:	SURS
Report Number:	SUR-0553-Q

Detailed Field Definitions

Table 6.47 – Field Description

Field	Description
Period	The time frame reflected by the data on the report.
FYTD Period	The fiscal year to date period reflected by the FYTD data on the report.
Hospital	The hospital provider number and name.
City	The hospital's city.
Peer Group	The reporting hospital's peer group code and description.
DRG	Diagnosis related grouping code.
DRG Freq	The frequency, or occurrences, of the specific DRG code.
DRG MLOS	The mean length of stay for the DRG.
Avg LOS	Average length of stay for the DRG, calculated as follows: Avg LOS = (Discharge Dates - Admit Dates) DRG Frequency
PGA LOS	Peer Group average length of stay, calculated as follows: (Sum of PG Discharge Dates - Sum of PG Admit Dates) Sum of Peer Group DRG Frequency

Table 6.48 – Exceptions:

Field	Description
Hi	Number of occurrences where length of stay is 2 or more standard deviations higher than the DRG mean length of stay.
Weight	Exception weight accrued for deviation above DRG mean length of stay, calculated as follows: Hi Exception = (LOS - MLOS) x 100 MLOS
LO	Number of occurrences where length of stay is 2 or more days less than the DRG mean length of stay.
Weight	Exception weight accrued for deviation below the DRG mean length of stay, calculated as follows: Lo Exception = (MLOS - LOS) x 100 MLOS
Amount Billed	Total amount billed for each DRG and totals, calculated from the claim details.
Amount Paid	Total amount paid for each DRG and totals, calculated for the claim header (DRG paid amount).
Hospital Totals	Cumulative totals for the reporting period.
FYTD Totals	Cumulative totals for the fiscal year to present.

Report Example: DRG Length of Stay Detail

REPORT: SUR-0553-Q INDIANA AIM DATE: 10/23/00
PROCESS: DSIBMUD6 DRG LENGTH OF STAY BY DETAILS TIME: 14:01:33
LOCATION: HUGP553B PERIOD: MM/YY THRU MM/YY PAGE: 1
YTD PERIOD: MM/YY THRU MM/YY

HOSPTIAL 999999999 AUDUBON REGIONAL MED CTR- CITY LOULSVILLE PEER GROUP S10 ACUTE CARE HOSPITAL

						-------EXCEPTIONS-------				AMOUNT	AMOUNT	AVGRAGE
	DRG	DRG FREQ	DRG MLOS	AVG LOS	PGA LOS	HI	WEIGHT	LO	WEIGHT	BILLED	PAID	PAID
	127	1	5.5	5.0	5.1	0	0	0	0	16,004.13	4,295.57	4,295.57
	127	1	5.5	5.0	5.1	0	0	0	0	16,004.13	4,295.57	4,295.57
	127	1	5.5	5.0	5.1	0	0	0	0	16,004.13	4,295.57	4,295.57
	127	1	5.5	5.0	5.1	0	0	0	0	16,004.13	4,295.57	4,295.57
	127	1	5.5	5.0	5.1	0	0	0	0	16,004.13	4,295.57	4,295.57
	127	1	5.5	5.0	5.1	0	0	0	0	16,004.13	4,295.57	4,295.57
	127	1	5.5	5.0	5.1	0	0	0	0	16,004.13	4,295.57	4,295.57
	127	1	5.5	5.0	5.1	0	0	0	0	16,004.13	4,295.57	4,295.57
	127	1	5.5	5.0	5.1	0	0	0	0	16,004.13	4,295.57	4,295.57
	**											
HOSPITAL TOTALS		33				3	4325	6		1,476,114,54	234.987.34	12,345.34
YTD TOTALS		33				3	4325	6		1,476,114,54	234.987.34	12,345.34

Report Definition: SUR-0554-Q DRG Ancillary Distribution

Part I Report Definition Information

Functional Area:	SURS
Report Number:	SUR-0554-Q
Job Name:	DSIBMUD6
Report Title:	Ancillary Distribution

Description of Information

The Ancillary Distribution Report provides a distribution analysis for major ancillary groups for each DRG category. Data displayed is specific to each hospital with comparison to relative peer group and statewide accumulations. Each major ancillary group within a DRG category details the number of occurrences, total ancillary charges billed and the average ancillary charge per occurrence.

Purpose of Report

The Ancillary Distribution Report may be used to evaluate a facility's ancillary charges. Although the DRG reimbursement methodology is set payment, ancillary charges billed by the facility affect the future DRG payments when historical costs and payments are reassessed during DRG rebasing. The Ancillary Distribution Report may be used to evaluate a facility's ancillary charges to determine if a facility may be "padding" these charges in anticipation of higher payments in the future.

Sort Sequence

Peer group, hospital number

Distribution

Distribution	Media	Copies	Frequency
EDS	CRLD		Quarterly
IFSSA	CRLD		Quarterly

DRG Ancillary Distribution

Part II Report Definition Information

Functional Area: SURS

Report Number: SUR-0554-Q

Detailed Field Definitions

Table 6.49 – Field Description

Field	Description
Period	The time frame reflected by the data on the report.
Hospital	Hospital provider number and name.
City	Hospital's city.
Peer Group	Reporting hospital's peer group code and description.
DRG Category	Categorized related DRG code category definition.
Anc	Cross-referenced major ancillary grouping code.

Table 6.50 – This Hospital:

Field	Description
Occur	Number of occurrences by this hospital for this major ancillary category, for this DRG category.
Amt Billed	Total dollars billed by this hospital for this major ancillary category, for this DRG category.
Avg Billed	Avg dollars billed by this hospital for this major ancillary category, for this DRG category, calculated as follows: Avg Billed = $\frac{\text{Amt Billed}}{\text{Occurrences}}$

Table 6.51– Peer Group:

Field	Description
Occur	Number of occurrences by this hospital's peer group for this major ancillary category, for this DRG category.
Amt Billed	Total dollars billed by this hospital's peer group for this major ancillary category, for this DRG category.

Table 6.51– Peer Group:

Field	Description
Avg Billed	Avg dollars billed by this hospital's peer group for this major ancillary category, for this DRG category, calculated as follows: Avg Billed = Amt Billed / Occurrences

Table 6.52 – Statewide:

Field	Description
Occur	Number of occurrences by all hospitals for this major ancillary category, for this DRG category.
Amt Billed	Total dollars billed by all hospitals for this major ancillary category, for this DRG category.
Avg Billed	Avg dollars billed by all hospitals for this major ancillary category, for this DRG category, calculated as follows: Avg Billed = Amt Billed / Occurrences

Report Example: DRG Ancillary Distribution

```
  REPORT:   SUR-0554-Q                               INDIANA AIM                                                DATE: 10/23/00
 PROCESS:   DSIBMUD6                            ANCILLARY DISTRIBUTION                                          TIME: 14:01:33
LOCATION:   HUGP554B                           PERIOD: MM/YY THRU MM/YY                                         PAGE:       1

HOSPTIAL    999999999           AUDUBON REGIONAL MED CTR-   CITY LOULSVILLE               PEER GROUP S10    ACUTE CARE HOSPITAL
```

DRG CATEGORY	ANC	THIS HOSPITAL OCCURR	THIS HOSPITAL AMT BILLED	THIS HOSPITAL AVG BILLED	PEER GROUP OCCURR	PEER GROUP AMT BILLED	PEER GROUP AVG BILLED	STATEWIDE OCCURR	STATEWIDE AMT BILLED	STATEWIDE AVG BILLED
MEDICAL DX / DRG	110	0	23,234.34	3,345.34	456	987,234.34	1,234.34	546	234,234.34	2,345.77
	110	0	23,234.34	3,345.34	456	987,234.34	1,234.34	546	234,234.34	2,345.77
	110	0	23,234.34	3,345.34	456	987,234.34	1,234.34	546	234,234.34	2,345.77
	110	0	23,234.34	3,345.34	456	987,234.34	1,234.34	546	234,234.34	2,345.77
	110	0	23,234.34	3,345.34	456	987,234.34	1,234.34	546	234,234.34	2,345.77
	110	0	23,234.34	3,345.34	456	987,234.34	1,234.34	546	234,234.34	2,345.77
	110	0	23,234.34	3,345.34	456	987,234.34	1,234.34	546	234,234.34	2,345.77
	110	0	23,234.34	3,345.34	456	987,234.34	1,234.34	546	234,234.34	2,345.77
	110	0	23,234.34	3,345.34	456	987,234.34	1,234.34	546	234,234.34	2,345.77
	110	0	23,234.34	3,345.34	456	987,234.34	1,234.34	546	234,234.34	2,345.77

Report Definition: SUR-0590-Q DRG Merged History

Part I Report Definition Information

Functional Area:	SURS
Report Number:	SUR-0590-Q
Job Name:	DSIBMUD7
Report Title:	DRG Merged History

Description of Information

The DRG Merged History Report provides a comprehensive summary of the episode of illness for each exception case reported on the Physician Length of Stay Exception Report. All claim activity for the recipient during hospitalization, 31 days prior to admission and 31 days following discharge is displayed.

Purpose of Report

The DRG Merged History Report can be used by the analyst to research the medical care activity surrounding length of stay exception cases. The care provided prior to, during and subsequent to a hospital admission is key in determining the reasonableness of an inpatient stay that has been flagged as shorter or longer than the norm for the diagnosis billed.

Sort Sequence

Recipient number

Distribution

Distribution	Media	Copies	Frequency
EDS	CRLD		Quarterly
IFSSA	CRLD		Quarterly

DRG Merged History

Part II Report Definition Information

Functional Area: SURS

Report Number: SUR-0590-Q

Detailed Field Definitions

Table 6.53 – Field Description

Field	Description
Period	The time frame reflected by the data on the report.
Recipient	The recipient's Medicaid identification and name.
Age	The recipient's age.
Sex	The recipient's sex.
Hospital	Hospital provider number and name.
City	Hospital's city.
Peer Group	Reporting hospital's peer group code and description.
Admission	Date of admission of the inpatient exception claim.
Discharge	Date of discharge of the inpatient exception claim.
LOS	The length of stay of the inpatient exception claim, calculated as follows:
	LOS = Discharge Date – Admit Date
Type Stay	The type of stay of the inpatient exception claim, as assigned to the DRG in the DRG Control Members. (MED or SURG)
Principal Diag	Principal discharge diagnosis code from the inpatient exception claim.
DRG	The diagnosis related grouping assigned to the inpatient exception claim.
MLOS	The mean length of stay for the DRG assigned to the inpatient exception claim.
ICN	Internal claim number of the inpatient exception claim.
SOA	Source of admission code from the inpatient exception claim.
Disch Code	Patient status discharge code from the inpatient exception claim.
Amount Billed	Amount billed for the inpatient exception claim, calculated from the claim details.
Amount Paid	Amount paid for the inpatient exception claim, calculated from the claim header (DRG amount paid).
Paid Date	Remittance Advise disposition date of the inpatient exception claim.
Provider	Provider number from the "surrounding claim".
Name	Provider's name.
DOS	The date of service for the "surrounding claim" detail.
Diag	Principal diagnosis for the "surrounding claim".
Proc	The procedure code billed for the "surrounding claim".
N/S	The number of services billed for the procedure.
Pl Serv	The place of service billed on the "surrounding claim".
Paid Date	Remittance Advise date of the "surrounding claim".
Paid Amount	Amount paid for the "surrounding claim" detail.

Table 6.53 – Field Description

Field	Description
ICN	Internal claim number of the "surrounding claim".
Total Provider Payment	Total amount paid to all providers for services surrounding and during this hospitalization.
Total Number Providers	Total number of providers who provided services during this hospitalization, 31 days prior and 31 days following.
Total Number Services	Total number of services billed surrounding and during this hospitalization.

Report Example: DRG Merged History

```
  REPORT:   SUR-0590-Q                              INDIANA AIM                                                     DATE: 10/23/00
 PROCESS:   DSIBMUD7                               MERGED HISTORY                                                   TIME: 14:01:33
LOCATION:   HUGP590B                          PERIOD: MM/YY THRU MM/YY                                              PAGE:       1

RECIPIENT  99999999999   PHELPS       D          AGE  013           SEX M          PEER GROUP 093   OTHER / OUT OF STATE
HOSPITAL   99999999    MEMORIAL HOSPITAL      CITY  INDIANAPOLIS

                                 TYPE    PRINCIPAL                                               DISCH  AMOUNT       AMOUNT              PAID
ADMISSION     DISCHARGE   LOS    STAY      DIAG     DRG    MLOS          ICN                     CODE   BILLED       PAID                DATE
06/06/00      06/07/00     1     MED       53642    455    10.2      9999999999999                03   3,373.18    9,611.12            07/26/00

PROVIDER              NAME           DOS           DIAG          PROC         N/S    POS     PAID DATE    PAID AMOUNT          ICN

999999999      ECKERT              05/08/00       7070        98908          1.0     31     05/30/00           24.67     999999999999
999999999      ECKERT              05/08/00       7070        98908          1.0     31     05/30/00           24.67     999999999999
999999999      ECKERT              05/08/00       7070        98908          1.0     31     05/30/00           24.67     999999999999
999999999      ECKERT              05/08/00       7070        98908          1.0     31     05/30/00           24.67     999999999999
999999999      ECKERT              05/08/00       7070        98908          1.0     31     05/30/00           24.67     999999999999
999999999      ECKERT              05/08/00       7070        98908          1.0     31     05/30/00           24.67     999999999999
999999999      ECKERT              05/08/00       7070        98908          1.0     31     05/30/00           24.67     999999999999
999999999      ECKERT              05/08/00       7070        98908          1.0     31     05/30/00           24.67     999999999999
999999999      ECKERT              05/08/00       7070        98908          1.0     31     05/30/00           24.67     999999999999
999999999      ECKERT              05/08/00       7070        98908          1.0     31     05/30/00           24.67     999999999999
999999999      ECKERT              05/08/00       7070        98908          1.0     31     05/30/00           24.67     999999999999
999999999      ECKERT              05/08/00       7070        98908          1.0     31     05/30/00           24.67     999999999999
999999999      ECKERT              05/08/00       7070        98908          1.0     31     05/30/00           24.67     999999999999
999999999      ECKERT              05/08/00       7070        98908          1.0     31     05/30/00           24.67     999999999999

TOTAL PROVIDER PAYMENT     6,987.02         TOTAL NUMBER PROVIDERS       12        TOTAL NUMBER SERVICES     345
```

Report Definition: SUR-0595-Q DRG Physician Length of Stay Exception

Part I Report Definition Information

Functional Area:	SURS
Report Number:	SUR-0595-Q
Job Name:	DSIBMUD8
Report Title:	DRG Physician Length of Stay Exception

Description of Information

The DRG Physician Length of Stay Exception Report identifies the top 10 attending physicians in each hospital who are responsible for the majority of admissions to the facility and who may be responsible for exceptionally high lengths of stay, and the top 10 who may be responsible for premature discharges (low lengths of stay). All exception cases are listed for each ranking physician, and descriptive summary data is displayed.

Purpose of Report

The DRG Physician Length of Stay Exception Report can be used to further research the top exception cases that a hospital had on the Length of Stay Detail Report. By referencing the attending physician number associated with each case, a pattern may be noticed with reference to a specific physician responsible for the exceptions in the hospital.

Sort Sequence

Hospital number

Distribution

Distribution	Media	Copies	Frequency
EDS	CRLD		Quarterly
IFSSA	CRLD		Quarterly

DRG Physician Length of Stay Exception

Part II Report Definition Information

Functional Area: SURS

Report Number: SUR-0595-Q

Detailed Field Definitions

Table 6.54 – Field Description

Field	Description
Hospital	Hospital provider number and name.
City	Hospital's city.
Peer Group	Reporting hospital's peer group code and description.
Rank	Relative rank of provider among all providers reported. Rank of 1 is assigned to provider whose admission is most deviant from DRG MLOS. The top 10 "Hi" and top 10 "Lo" are reported.
Provider Number	Admitting / attending physician's Medicaid identification.
Recipient Number	Recipient's Medicaid number.
Admit Date	Date of admission.
ICN	Internal control number.
DRG	Diagnosis related grouping assigned to this hospitalization.
MLOS	Mean length of stay assigned to the reported DRG.
LOS	Actual length of stay for this hospitalization, calculated as follows: LOS = Discharge Date - Admit Date
Excp	Exception: H = 2 standard deviations greater than the DRG MLOS L = 2 or more days less than the DRG MLOS
Weight	Exception weight assigned to this deviation from the MLOS, calculated as follows: $\text{High} = \frac{(\text{LOS} - \text{MLOS})}{\text{MLOS}} \times 100$ $\text{Low} = \frac{(\text{MLOS} - \text{LOS})}{\text{MLOS}} \times 100$
TOS	Type of admission.
SOA	Source of admission.
Disch Stat	Patient discharge status.

Table 6.54 – Field Description

Field	Description
TF	Transfer indicator ("*"); flags if transfer is indicated by SOA code 04, 05, 06 and/or discharge status code 02, 03, 04, 05.
Previous Admit	Date of previous admission; previous admit = previous claim discharge date less than 31 days prior to current admission.
590 Page	Page number of the 590 Merged History Report which contains a complete case history surrounding this hospitalization.

Report Example: DRG Physician Length of Stay Exception

```
  REPORT:   SUR-0595-Q                              INDIANA AIM                                        DATE: 10/23/00
 PROCESS:   DSIBMUD8                  PHYSICIAN LENGTH OF STAY BY EXCEPTIONS                          TIME: 14:01:33
LOCATION:   HUGP595B                      PERIOD: MM/YY THRU MM/YY                                   PAGE:       1

HOSPTIAL    999999999          AUDUBON REGIONAL MED CTR-   CITY LOULSVILLE              PEER GROUP S10    ACUTE CARE HOSPITAL

      PROVIDER       RECIPIENT     ADMIT                                                                DSCH       PREVIOUS   SURO590
RANK   NUMBER         NUMBER       DATE          ICN            DRG  MLOS  LOS EXCP  WEIGHT  TOA      STAT  TF    ADMIT      PAGE

H 01  999999999     999999999999  09/08/95    9999999999999      144   6.0  024  H      300    1         03    *                8,698
H 01  999999999     999999999999  09/08/95    9999999999999      144   6.0  024  H      300    1         03                     8,698
H 01  999999999     999999999999  09/08/95    9999999999999      144   6.0  024  H      300    1         03                     8,698
H 01  999999999     999999999999  09/08/95    9999999999999      144   6.0  024  H      300    1         03    *                8,698
H 01  999999999     999999999999  09/08/95    9999999999999      144   6.0  024  H      300    1         03    *                8,698
H 01  999999999     999999999999  09/08/95    9999999999999      144   6.0  024  H      300    1         03    *                8,698
H 01  999999999     999999999999  09/08/95    9999999999999      144   6.0  024  H      300    1         03                     8,698

L 01  999999999     999999999999  09/08/95    9999999999999      144   6.0  024  H      300    1         03    *                8,698
L 01  999999999     999999999999  09/08/95    9999999999999      144   6.0  024  H      300    1         03    *                8,698
L 01  999999999     999999999999  09/08/95    9999999999999      144   6.0  024  H      300    1         03    *                8,698
L 01  999999999     999999999999  09/08/95    9999999999999      144   6.0  024  H      300    1         03    *                8,698
L 01  999999999     999999999999  09/08/95    9999999999999      144   6.0  024  H      300    1         03    *                8,698
L 01  999999999     999999999999  09/08/95    9999999999999      144   6.0  024  H      300    1         03    *                8,698
L 01  999999999     999999999999  09/08/95    9999999999999      144   6.0  024  H      300    1         03                     8,698
L 01  999999999     999999999999  09/08/95    9999999999999      144   6.0  024  H      300    1         03    *                8,698
```

LTC Reporting

The reports produced in the long term care subsystem were designed to provide a comprehensive picture of medical assistance program services provided in the long term care setting. Reported, are services performed within the long term facilities, as well as those performed by inpatient, outpatient, pharmacy, dental and transportation providers.

The following reports are produced:

- LTC Provider
- LTC Summary
- LTC Summary Detail Non-Drug
- LTC Summary Detail Drug
- LTC Summary Detail Combined
- LTC Summary Detail Non-Drug Wraparound
- LTC Summary Detail Drug Wraparound
- LTC Summary Detail Combined Wraparound

These reports analyze claim activity from the perspective of the long term care facility as the administrator of services provided to its residents and from the perspective of the performing providers who serve long term care facility recipients. Use of the LTC reports is intended to assist the user in performing the following functions.

- Assess the quality and quantity of services provided to recipients who reside in each long term care facility.
- Determine the medical care needs of the long term care population according to the level of extended care they require.
- Isolated cases in which performing provider services are over or under utilized by individual facilities.
- Analyze physician services provided in long term care facilities to detect possible duplication of services.
- Study the activity of individual performing providers within the long term care setting.

Report Definition: SUR-0610-Q Long Term Care Provider

Part I Report Definition Information

Functional Area:	SURS
Report Number:	SUR-0610-Q
Job Name:	DSIBMUL2
Report Title:	Long Term Care Provider

Description of Information

The Long Term Care Provider Report provides detailed data on the services provided to LTC recipients from the perspective of the individual performing provider.

Purpose of Report

In cases when a provider has been identified as having a high volume of practice in the long term care setting, this report can be used to analyze the distribution of services among different facilities and the types of services performed for facility residents.

This report can be used not only to obtain information about the scope and nature of a provider's practice in LTC facilities, but also to cross-check information displayed on the LTC Summary Detail Reports. These reports display LTC facility data for all performing providers of a selected provider type. If a provider has been identified in those reports as having duplicated services performed by other providers, he and the other providers can be further investigated through the LTC Provider Report to determine whether they are involved in the same duplication of services in other facilities.

In cases when a provider is the primary performing provider for a facility that has been found lacking in the quality of care provided to its recipients, the report can be used to determine if the provider is involved with other facilities that have also been identified as administering substandard care.

Sort Sequence

Performing provider ID number, nursing home provider ID

Distribution

Distribution	Media	Copies	Frequency
EDS	CRLD		Quarterly
IFSSA	CRLD		Quarterly

Long Term Care Provider

Part II Report Definition Information

Functional Area: SURS

Report Number: SUR-0610-Q

Detailed Field Definitions

Table 6.55 – Field Description

Field	Description
Period	The period for the data extracted and summarized on this report.
Provider No	The performing provider identification number which is keyed into the 50 control file. These are the providers who performed services for recipients in nursing home facilities.
Name	The performing provider name.
Address	The performing provider address.
Spec	The performing provider specialty code.
City	The performing provider city.
Facility No	The facility identification number.
Name	The nursing home facility name of which the recipient is enrolled during the period that recipient receives services from the requested performing provider.
Address	The nursing home facility address.
Type	The description of the long term care facility's specialty.
DOS	The from and to dates of service on the claim detail MM/DD/CCYY date format.
RID	The recipient identification number of the nursing home recipient.
Last Name	The nursing home recipient's last name.
First Name	The nursing home recipient's first name.
MI	Middle initial.
Age	The nursing home recipient's age for the first date of service.
Proc	The procedure code, service code, revenue center code, or National Drug Code being reported.
Description	The procedure group code description.
Amt Pd	The amount paid for this detail.

Table 6.56 – Facility Totals

Field	Description
No Visits	The total number of visits by the performing provider for this recipient staying in the nursing home facility.

Table 6.56 – Facility Totals

Field	Description
No Recip Seen	The unduplicated recipient count seen by the performing provider in the nursing home facility for this reporting period.
No TS/Proc	The unduplicated procedure count for this facility. The total of unique procedure values that occur for a specific provider at a specific facility
Total Amt Pd	The total amount paid to this performing provider for services rendered to recipients in this nursing home facility.

Table 6.57 – Provider Totals

Field	Description
No Visits	The total number of visits by the provider for recipients staying in each type of Long Term Care facility.
No Recip Seen	The unduplicated recipient count seen by the provider, categorized for each type of Long Term Care facility, in the reporting period.
No TS/Proc	The unduplicated procedure count performed by the provider, categorized for each type of long term care facility.
Amt Pd	The total amount paid to the performing provider for services rendered, categorized by each type of long term care facility.

Report Example: Long Term Care Provider

```
REPORT:  SUR-0610- Q                                         INDIANA AIM                                         DATE: MM/DD/CCYY
 PROCESS:  DSIBMUL2                                        LTC PROVIDER REPORT                                     TIME: 11:38:23
LOCATION:  HUGS610B                                      PERIOD: MM/CCYY THRU MM/CCYY                              PAGE:      1

PROV NUM     XXXXXXX    NAME XXXXXXXXXXXXXXXXXXXXXXXXXXXXXX    ADDRESS XXXXXXXXXXXXXXXXXXXX     SPC  XXX
                                                                  CITY: XXXXXXXXXX
   FACILITY NO: XXXXXXX    NAME XXXXXXXXXXXXXXXXXXXXXXXXXXXXXX    ADDRESS XXXXXXXXXXXXXXXXXXXX     TYPE:  XXXXXXXXXXX
                                                                     CITY: XXXXXXXXXX
         DOS               RID     LAST NAME          FIRST NAME   MI    AGE    PROC      DESCRIPTION               AMT PD
MM/DD/CCYY  MM/DD/CCYY  XXXXXXXXXXX  XXXXXXXXXXXXXXX  XXXXXXXXXXX   X      999    XXXXX     XXXXXXXXXXXXXXX     $999,999.99
         FACILITY TOTALS     NO VISITS -  9999   NO CLNT SEEN -   9999   NO TS/PROC -  9999    TOTAL AMT PD -  99,999,999.99
   FACILITY NO: XXXXXXX    NAME XXXXXXXXXXXXXXXXXXXXXXXXXXXXXX    ADDRESS XXXXXXXXXXXXXXXXXXXX     TYPE:  XXXXXXXXXXX

         DOS               RID     LAST NAME          FIRST NAME   MI    AGE    PROC      DESCRIPTION               AMT PD
MM/DD/CCYY  MM/DD/CCYY  XXXXXXXXXXX  XXXXXXXXXXXXXXX  XXXXXXXXXXX   X      999    XXXXX     XXXXXXXXXXXXXXX     $999,999.99
MM/DD/CCYY  MM/DD/CCYY  XXXXXXXXXXX  XXXXXXXXXXXXXXX  XXXXXXXXXXX   X      999    XXXXX     XXXXXXXXXXXXXXX     $999,999.99
MM/DD/CCYY  MM/DD/CCYY  XXXXXXXXXXX  XXXXXXXXXXXXXXX  XXXXXXXXXXX   X      999    XXXXX     XXXXXXXXXXXXXXX     $999,999.99
MM/DD/CCYY  MM/DD/CCYY  XXXXXXXXXXX  XXXXXXXXXXXXXXX  XXXXXXXXXXX   X      999    XXXXX     XXXXXXXXXXXXXXX     $999,999.99
         FACILITY TOTALS     NO VISITS -  9999   NO CLNT SEEN -   9999   NO TS/PROC -  9999    TOTAL AMT PD -  99,999,999.99
   FACILITY NO: XXXXXXX    NAME XXXXXXXXXXXXXXXXXXXXXXXXXXXXXX    ADDRESS XXXXXXXXXXXXXXXXXXXX     TYPE:  XXXXXXXXXXX


PROVIDER TOTALS:         NO VISITS            NO RECIP SEEN            NO TS/PROC             AMT PD

      NURSING FACILITY      99999               99999                    99999            999,999,999.99
     MEDICARE COVERAGE      99999               99999                    99999            999,999,999.99
  NO MEDICARE COVERAGE      99999               99999                    99999            999,999,999.99
            I/O MENTAL      99999               99999                    99999            999,999,999.99
                ICF-MR      99999               99999                    99999            999,999,999.99
```

Report Definition: SUR-0620-Q Long Term Care Summary

Part I Report Definition Information

Functional Area:	SURS
Report Number:	SUR-0620-Q
Job Name:	DSIBMUL2
Report Title:	Long Term Care Summary

Description of Information

The Long Term Care Summary Report displays information for the long term care facilities by claim type. The claim type totals per facility are number of recipients, number of performing providers, amount paid to performing providers, and percent of total performing provider payment. The claim type totals for all LTC facilities are number of providers, number of recipients, number of performing providers, and amount paid to performing providers. The summary report also includes recipient placement level totals and grand totals.

Purpose of Report

Medical inpatient care comprises a greater percentage of claim payments within skilled nursing facilities. This information can be useful in the design of special programs, such as waiver services focused at a particular level of care.

The number of recipients served and the associated expenditures for each claim type may also be used to select review cases. For instance, dental services in a given facility may be provided to a much smaller proportion of its residents than is seen among other facilities with the same level of care. This data may indicate a need for more in-depth review of the facility to determine if adequate care is being provided to its residents.

Sort Sequence

Facility number, claim type

Distribution

Distribution	Media	Copies	Frequency
EDS	CRLD		Quarterly
IFSSA	CRLD		Quarterly

LTC Summary Report

Part II Report Definition Information

Functional Area: SURS

Report Number: SUR-0620-Q

Detailed Field Definitions

Table 6.58 – Field Description

Field	Description
Period	The period for the data extracted and summarized on this report.
Prov	The nursing home facility/provider identification number.
Name	The nursing home name.
Spec	The nursing home provider specialty code.
Location	The provider's town code.
Beds	The number of beds in the nursing home. The number of beds value is taken from the provider file when used.
Claim Type Totals:	Totals for each claim type submitted for recipients residing in the LTC facility.
Claim Type	The claim type description.
No Recip	The unduplicated recipient count for this claim type for this facility.
No Perf Providers	The unduplicated performing provider count for the claim type for this facility.
Amt Paid to Perf Providers	The amount paid to all performing providers by claim type for this facility.
Pct of Total Perf Prov Pmt	The percent paid to the performing provider, for this claim type, calculated as follows: Amt Pd to Perf Prov for Claim Type Amt Pd to Perf Prov (total for facility)

Table 6.59 – Report Totals:

Field	Description
Claim Type Totals:	The totals for each claim type within long term care facilities.
No Providers	The unduplicated provider count for this placement level.
No Recip	The unduplicated recipient count for this placement level.
No Perf Providers	The unduplicated performing provider count for this placement level.
Amt Paid to Perf Providers	The amount paid to all performing providers for this placement level.
Recipient Placement Level:	The totals for each placement level, regardless of claim type.

Table 6.59 – Report Totals:

Field	Description
No Providers	The unduplicated provider count for all claim types at this placement level.
No Recip	The unduplicated recipient count for all claim types at this placement level.
No Perf Providers	The unduplicated performing provider count for all claim types at this placement level.
Amt Pd to Perf Providers	The total amount paid for all claim types at this placement level.
[Grand Totals]:	Totals, regardless of claim type or placement level.
No of Recip	The unduplicated recipient count for the report period.
No of Perf Providers	The unduplicated performing provider count for the report period.
Amt Paid to Perf Providers	The amount paid to all performing providers for the report period.

Report Example: Long Term Care Summary

```
  REPORT:   SUR-0620-Q                                INDIANA AIM                                DATE: 10/23/00
 PROCESS:   DSIBMUL2                              LTC SUMMARY REPORT                            TIME: 14:01:33
LOCATION:   HUGP620B                          PERIOD: MM/CCYY THRU MM/CCYY                     PAGE:       1

     PROV        999999999    NAME XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX        SPC  999    LOCATION  99    BEDS  9999

                                                 NO PERF          AMT PAID TO            PCT OF TOTAL
  CLAIM TYPE                    NO RECIP        PROVIDERS        PERF PROVIDERS          PERF PROV PMT
CROSSOVER UB92 INPATIENT         999,999         999,999       9,999,999.99               999.99
CROSSOVER HCFA 1500              999,999         999,999       9,999,999.99               999.99
CROSSOVER UB92 OUTPATIENT        999,999         999,999       9,999,999.99               999.99
DENTAL                           999,999         999,999       9,999,999.99               999.99
HCFA 1500                        999,999         999,999       9,999,999.99               999.99
HOME HEALTH                      999,999         999,999       9,999,999.99               999.99
INPATIENT                        999,999         999,999       9,999,999.99               999.99
NURSING HOME                     999,999         999,999       9,999,999.99               999.99
OUTPATIENT                       999,999         999,999       9,999,999.99               999.99
PHARMACY                         999,999         999,999       9,999,999.99               999.99
TOTAL FOR FACILITY               999,999         999,999       9,999,999.99               999.99

REPORT TOTALS:

  CLAIM TYPE TOTALS:
                                                                    NO PERF          AMT PD TO
                           NO PROVIDERS          NO RECIP          PROVIDERS       PERF PROVIDERS
         NURSING FACILITY       999,999          999,999       9,999,999.99               999.99
CROSSOVER UB92 INPATIENT        999,999          999,999       9,999,999.99               999.99
CROSSOVER HCFA 1500             999,999          999,999       9,999,999.99               999.99
CROSSOVER UB92 OUTPATIENT       999,999          999,999       9,999,999.99               999.99
DENTAL                          999,999          999,999       9,999,999.99               999.99
HCFA 1500                       999,999          999,999       9,999,999.99               999.99
HOME HEALTH                     999,999          999,999       9,999,999.99               999.99
INPATIENT                       999,999          999,999       9,999,999.99               999.99
NURSING HOME                    999,999          999,999       9,999,999.99               999.99
OUTPATIENT                      999,999          999,999       9,999,999.99               999.99
PHARMACY                        999,999          999,999       9,999,999.99               999.99
TOTAL FOR FACILITY              999,999          999,999       9,999,999.99               999.99

  RECIPIENT PLACEMENT LEVEL:
         NURSING FACILITY        99,999          999,999           999,999          9,999,999.99
                  ICF/MR         99,999          999,999           999,999          9,999,999.99
PEDIATRIC NURSING FACILITY       99,999          999,999           999,999          9,999,999.99
 RESIDENTIAL CARE FACILITY       99,999          999,999           999,999          9,999,999.99
             GRAND TOTALS:       99,999          999,999           999,999          9,999,999.99
```

Report Definition: SUR-0631-Q Long Term Care Summary Detail Non-Drug

Part I Report Definition Information

Functional Area:	SURS
Report Number:	SUR-0631-Q
Job Name:	DSIBMUL2
Report Title:	Long Term Care Summary Detail Non-Drug

Description of Information

The Long Term Care Summary Detail Non-Drug Report produces non-drug summary detail information on recipients including hospital stay dates of service, recipient's medical identification, age, type of service/procedure, number of services performed for the recipient, amount billed for this recipient, and amount paid for this recipient. Provider type totals are number of recipients, amount billed, and amount paid (for a particular provider type). Only claim details that have dates of service during a recipient's enrollment in a nursing home facility are reported. All claim types are reported except drug and long-term care claims.

Purpose of Report

The Long Term Care Summary Detail Non-Drug Report may be used to analyze recipient and claim data during a specific time frame for any provider servicing recipients of a long term care facility. When the LTC Summary Report shows an unusual amount of medical claims for an intermediate care facility, the date of service information on the LTC Detail Report may indicate that physical exams are performed on the same recipients more often than is acceptable.

Sort Sequence

Facility/provider number, attending provider number, RID

Distribution, Media, Copies, and Frequency

Distribution	Media	Copies	Frequency
EDS	CRLD		Quarterly
IFSSA	CRLD		Quarterly

Long Term Care Summary Detail Non-Drug

Part II Report Definition Information

Functional Area: SURS

Report Number: SUR-0631-Q

Detailed Field Definitions

Table 6.60 Field Description

Field	Description
Period	The period for the data extracted and summarized on this report.
Facility	The long term care facility identification number.
Name	The long term care facility name.
Address	The long term care facility address.
Spec	The nursing home provider specialty code.
Location	The nursing home/provider's location code.
Prov Type	The attending provider type code.
Att Prov	The attending provider number.
FDOS	The beginning date of service on the claim detail MM/DD/YY date format.
TDOS	The end date of service on the claim detail MM/DD/YY date format.
RID	The identification number of the nursing home recipient.
Last Name	Recipient's last name.
First Name	Recipient's first name.
Age	The nursing home recipient's age during the date of service.
Proc	The procedure code that indicates the procedure the nursing home recipient receives while at the nursing home.
Qty	The quantity of services for the procedure.
Amt Billed	The amount billed for this detail.
Pd Amt	The amount paid for this detail.
Pct Tot Prov Pmt	The percent paid, calculated as follows: Amt Pd for this Detail Amt Pd for Entire Prov Type
Provider Type Totals:	Totals within the facility for the particular attending provider type.
No Recip	This is an unduplicated recipient count for this particular provider type.
Amt Billed	The total amount billed by this particular provider type.
Amt Paid	The total amount paid to this particular provider type.

Report Example: Long Term Care Summary Detail Non-Drug

```
  REPORT:    SUR-0631-Q                                 INDIANA AIM                                                 DATE: 10/23/00
 PROCESS:    DSIBMUL2                        LTC SUMMARY DETAIL NON-DRUG REPORT                                     TIME: 14:01:33
LOCATION:    HUGP630B                             PERIOD: MM/YY THRU MM/YY                                          PAGE:        1

FACILITY:    XXXXXXX   NAME XXXXXXXXXXXXXXXXXXXXXXXXXXXXXX   ADDRESS XXXXXXXXXXXXXXXXXXXXXXXXX      SPC  999        LOCATION  99

  PROV TYPE  XXX

    ATT PROV    99999999
                                                                                                                         PCT TOT
  FDOS       TDOS            RID     LAST NAME       FIRST NAME   AGE    PROC        QTY      AMT BILLED         PD AMT      PROV PMT

MM/DD/CCYY MM/DD/CCYY  9999999999  XXXXXXXXXXXXXXX XXXXXXXXXXX    999             99999    999,9999.99    999,999.99         999.99
                                                                     XXXXXXXXXXXXXXXXXXXX
MM/DD/CCYY MM/DD/CCYY  9999999999  XXXXXXXXXXXXXXX XXXXXXXXXXX    999             99999    999,9999.99    999,999.99         999.99
                                                                     XXXXXXXXXXXXXXXXXXXX
MM/DD/CCYY MM/DD/CCYY  9999999999  XXXXXXXXXXXXXXX XXXXXXXXXXX    999             99999    999,9999.99    999,999.99         999.99
                                                                     XXXXXXXXXXXXXXXXXXXX
MM/DD/CCYY MM/DD/CCYY  9999999999  XXXXXXXXXXXXXXX XXXXXXXXXXX    999             99999    999,9999.99    999,999.99         999.99
                                                                     XXXXXXXXXXXXXXXXXXXX
MM/DD/CCYY MM/DD/CCYY  9999999999  XXXXXXXXXXXXXXX XXXXXXXXXXX    999             99999    999,9999.99    999,999.99         999.99
                                                                     XXXXXXXXXXXXXXXXXXXX
MM/DD/CCYY MM/DD/CCYY  9999999999  XXXXXXXXXXXXXXX XXXXXXXXXXX    999             99999    999,9999.99    999,999.99         999.99
                                                                     XXXXXXXXXXXXXXXXXXXX
MM/DD/CCYY MM/DD/CCYY  9999999999  XXXXXXXXXXXXXXX XXXXXXXXXXX    999             99999    999,9999.99    999,999.99         999.99
                                                                     XXXXXXXXXXXXXXXXXXXX
MM/DD/CCYY MM/DD/CCYY  9999999999  XXXXXXXXXXXXXXX XXXXXXXXXXX    999             99999    999,9999.99    999,999.99         999.99
                                                                     XXXXXXXXXXXXXXXXXXXX
MM/DD/CCYY MM/DD/CCYY  9999999999  XXXXXXXXXXXXXXX XXXXXXXXXXX    999             99999    999,9999.99    999,999.99         999.99
                                                                     XXXXXXXXXXXXXXXXXXXX
MM/DD/CCYY MM/DD/CCYY  9999999999  XXXXXXXXXXXXXXX XXXXXXXXXXX    999             99999    999,9999.99    999,999.99         999.99
                                                                     XXXXXXXXXXXXXXXXXXXX
MM/DD/CCYY MM/DD/CCYY  9999999999  XXXXXXXXXXXXXXX XXXXXXXXXXX    999             99999    999,9999.99    999,999.99         999.99
                                                                     XXXXXXXXXXXXXXXXXXXX
```

Report Definition: SUR-0632-Q Long Term Care Summary Detail Drug

Part I Report Definition Information

Functional Area:	SURS
Report Number:	SUR-0632-Q
Job Name:	DSIBMUL2
Report Title:	Long Term Care Summary Detail Drug

Description of Information

The Long Term Care Summary Detail Drug Report produces drug summary detail information on recipients including hospital stay dates of service, recipient's medical identification, age, National Drug Code, therapeutic class code, number of services performed for the recipient, amount billed for this recipient, amount paid for this recipient, and brand certification. Provider type totals are number of recipients, amount billed, and amount paid (for a particular provider type). Only drug claim type details that have dates of service during a recipient's enrollment in a nursing home facility are reported.

Purpose of Report

This report may be used to analyze claim data for long term care recipients by selected pharmacy providers when a larger than usual number of drug claims has been identified on other LTC reports.

Sort Sequence:

Facility/provider number, provider type, attending provider number, RID, from date of service

Distribution

Distribution	Media	Copies	Frequency
EDS	CRLD		Quarterly
IFSSA	CRLD		Quarterly

Long Term Care Summary Detail Drug

Part II Report Definition Information

Functional Area: SURS

Report Number: SUR-0632-Q

Detailed Field Definitions

Table 6.61 – Field Description

Field	Description
Period	The period for the data extracted and summarized on this report.
Facility	The long term care facility identification number.
Name	The long term care facility name.
Address	The long term care facility address.
Spec	The nursing home provider specialty code.
Location	The nursing home/provider's location code.
Prov Type	The provider type code.
Att Prov	The attending provider number.
FDOS	The beginning date of service on the claim detail MM/DD/CCYY date format.
TDOS	The end date of service on the claim detail MM/DD/CCYY date format.
RID	The identification number of the nursing home recipient.
Last Name	Recipient's last name.
Age	The nursing home recipient's age during the date of service.
NDC	The National Drug Code of the drug being reported.
Brand Cert	This field contains the brand certification code. The recipient should receive generic drugs unless a physician authorizes a brand name drug. 1 = brand name 2 = generic
TCC	Therapeutic class code of the drug.
Qty	The quantity of units for the drug.
Amt Billed	The amount billed for this detail.
Amt Pd	The amount paid for this detail.
Pct Tot Prov Pmt	The percent paid, calculated as follows Amt Pd for this Detail Amt Pd for Entire Prov Type

Table 6.61 – Field Description

Field	Description
[NDC Description]	The national drug code description.
Provider Type Totals:	Totals within the facility for the particular attending provider type.
No Recip	This is an unduplicated recipient count for this particular provider type.
Amt Billed	The total amount billed by this particular provider type.
Amt Paid	The total amount paid to this particular provider type.

Report Example: Long Term Care Summary Detail Drug

```
  REPORT:   SUR-0632-Q                            INDIANA AIM                                        DATE: 10/23/00
 PROCESS:   DSIBMUL2                      LTC SUMMARY DETAIL DRUG REPORT                             TIME: 14:01:33
LOCATION:   HUGP630B                           PERIOD: MM/YY THRU MM/YY                              PAGE:        1

FACILITY:   XXXXXXX   NAME XXXXXXXXXXXXXXXXXXXXXXXXXXXXXX   ADDRESS XXXXXXXXXXXXXXXXXXXXXXXXX      SPC  999      LOCATION  99

  PROV TYPE  999

    ATT PROV    99999999
                                                                                                                     PCT TOT
   FDOS       TDOS       RID       LAST NAME        AGE    NDC       BRAND CERT   TCC     QTY    AMT BILLED       AMT PD       PROV PMT


MM/DD/CCYY MM/DD/CCYY  99999999999 XXXXXXX          999 9999999999999              999      999   999,999.99     999,999.99         999.99
                                                        XXXXXXXXXXXXXXXXXXXX
MM/DD/CCYY MM/DD/CCYY  99999999999 XXXXXXX          999 9999999999999              999      999   999,999.99     999,999.99         999.99
                                                        XXXXXXXXXXXXXXXXXXXX
MM/DD/CCYY MM/DD/CCYY  99999999999 XXXXXXX          999 9999999999999              999      999   999,999.99     999,999.99         999.99
                                                        XXXXXXXXXXXXXXXXXXXX
MM/DD/CCYY MM/DD/CCYY  99999999999 XXXXXXX          999 9999999999999              999      999   999,999.99     999,999.99         999.99
                                                        XXXXXXXXXXXXXXXXXXXX
MM/DD/CCYY MM/DD/CCYY  99999999999 XXXXXXX          999 9999999999999              999      999   999,999.99     999,999.99         999.99
                                                        XXXXXXXXXXXXXXXXXXXX
MM/DD/CCYY MM/DD/CCYY  99999999999 XXXXXXX          999 9999999999999              999      999   999,999.99     999,999.99         999.99
                                                        XXXXXXXXXXXXXXXXXXXX
MM/DD/CCYY MM/DD/CCYY  99999999999 XXXXXXX          999 9999999999999              999      999   999,999.99     999,999.99         999.99
                                                        XXXXXXXXXXXXXXXXXXXX

   PROVIDER TYPE TOTALS:           NO RECIP -  9999        AMT BILLED -  99,999,999.99        AMT PAID -  99,999,999.99
```

Report Definition: SUR-0633-Q Long Term Care Summary Detail Combined

Part I Report Definition Information

Functional Area:	SURS
Report Number:	SUR-0633-Q
Job Name:	DSIBMUL2
Report Title:	Long Term Care Summary Detail Combined

Description of Information

The Long Term Care Summary Detail Combined Report produces drug and non-drug summary detail information on recipients including hospital stay dates of service, recipient's medical identification, age, National Drug Code, therapeutic class code, number of services performed for the recipient, amount billed for this recipient, amount paid for this recipient, and brand certification. Provider type totals are number of recipients, amount billed, and amount paid (for a particular provider type). Only claims that have dates of service during a recipient's enrollment in a nursing home facility are reported. All claim types are reported, except long-term care claims.

Purpose of Report

This report provides in depth information necessary to make a determination of misutilization in cases when exceptional activity has been noted within a specific LTC facility. The services provided by performing providers are displayed at the claim detail level to assist the user in identifying instances when services have been duplicated or over utilized.

Sort Sequence

Facility/provider number, provider type, attending provider number, RID, and from date of service

Distribution

Distribution	Media	Copies	Frequency
EDS	CRLD		Quarterly
IFSSA	CRLD		Quarterly

Long Term Care Summary Detail Combined

Part II Report Definition Information

Functional Area: SURS

Report Number: SUR-0633-Q

Detailed Field Definitions

Table 6.62 Field Description

Field	Description
Period	The period for the data extracted and summarized on this report.
Prov	The nursing home facility identification number.
Name	The long term care facility name.
Address	The long term care facility address.
Spec	The long term care facility provider specialty code.
Location	The long term care facility/provider's town code.
Type	The provider type code.
Provider No	The attending provider number.
FDOS	The beginning date of service on the claim detail MM/DD/YY date format.
TDOS	The end date of service on the claim detail MM/DD/CYY date format.
RID	The identification number of the nursing home recipient.
Last Name	Recipient's last name.
Age	The nursing home recipient's age during the date of service.
TS/Proc NDC	The procedure code or the National Drug Code being reported
Brand Cert	This field contains the brand certification code, when applicable. The recipient should receive generic drugs unless a physician authorizes a brand name drug. 1 = brand name 2= generic
TCC	Therapeutic class code of the drug, when applicable.
Qty	The quantity of units of service for the procedure, or units for the drug.
Amt Billed	The amount billed for this detail.
Amt Pd	The amount paid for this detail.
Pct Tot Prov Pmt	The percent paid, calculated as follows: Amt Pd for this Detail Amt Pd for Entire Prov Type

Table 6.62 Field Description

Field	Description
Provider Type Totals:	Totals within the facility for the particular provider type.
No Recip	This is an unduplicated recipient count for this particular provider type.
Amt Billed	The total amount billed by this particular provider type.
Amt Paid	The total amount paid to this particular provider type.

Report Example: Long Term Care Summary Detail Combined

```
REPORT:   SUR-0633-Q                                        INDIANA AIM                                              DATE: 10/23/00
 PROCESS:   DSIBMUL2                              LTC SUMMARY DETAIL COMBINED REPORT                                   TIME: 14:01:33
LOCATION:   HUGP630B                                   PERIOD: MM/YY THRU MM/YY                                        PAGE:        1

FACILITY:   XXXXXXX   NAME XXXXXXXXXXXXXXXXXXXXXXXXXXXXXX   ADDRESS XXXXXXXXXXXXXXXXXXXXXXXXX     SPC  999     LOCATION  99

  PROV TYPE  999

    ATT PROV    99999999
                                                                                                                          PCT TOT
   FDOS       TDOS       RID       LAST NAME        AGE     NDC        BRAND CERT   TCC      QTY    AMT BILLED       AMT PD      PROV PMT


MM/DD/CCYY MM/DD/CCYY  99999999999 XXXXXXX          999 9999999999999              999      999   999,999.99     999,999.99        999.99
                                                        XXXXXXXXXXXXXXXXXXXX
MM/DD/CCYY MM/DD/CCYY  99999999999 XXXXXXX          999 9999999999999              999      999   999,999.99     999,999.99        999.99
                                                        XXXXXXXXXXXXXXXXXXXX
MM/DD/CCYY MM/DD/CCYY  99999999999 XXXXXXX          999 9999999999999              999      999   999,999.99     999,999.99        999.99
                                                        XXXXXXXXXXXXXXXXXXXX
MM/DD/CCYY MM/DD/CCYY  99999999999 XXXXXXX          999 9999999999999              999      999   999,999.99     999,999.99        999.99
                                                        XXXXXXXXXXXXXXXXXXXX
MM/DD/CCYY MM/DD/CCYY  99999999999 XXXXXXX          999 9999999999999              999      999   999,999.99     999,999.99        999.99
                                                        XXXXXXXXXXXXXXXXXXXX
MM/DD/CCYY MM/DD/CCYY  99999999999 XXXXXXX          999 9999999999999              999      999   999,999.99     999,999.99        999.99
                                                        XXXXXXXXXXXXXXXXXXXX
MM/DD/CCYY MM/DD/CCYY  99999999999 XXXXXXX          999 9999999999999              999      999   999,999.99     999,999.99        999.99
                                                        XXXXXXXXXXXXXXXXXXXX

   PROVIDER TYPE TOTALS:           NO RECIP -  9999        AMT BILLED -  99,999,999.99        AMT PAID -  99,999,999.99
```

Report Definition: SUR-0634-Q Long Term Care Summary Detail Non-Drug Wraparound

Part I Report Definition Information

Functional Area:	SURS
Report Number:	SUR-0634-Q
Job Name:	DSIBMUL2
Report Title:	Long Term Care Summary Detail Non-Drug Wraparound

Description of Information

The Long Term Care Summary Detail Non-Drug Wraparound Report displays the recipient's total non-drug ambulatory and inpatient services provided to nursing home residents. The recipient detail includes hospital stay dates of service, type of service and procedure, number of services performed for this recipient, amount billed for this recipient, and amount paid for the services given the recipient in this detail. The recipient totals are the number of providers the recipient has seen, the total amount billed for this recipient, and the total amount paid for this recipient (per type of service). The report contains the same information as the LTC Summary Detail Non-Drug Report but this report is sorted in facility number, recipient number, and then provider number order.

Purpose of Report

The Long Term Care Summary Detail Non-Drug Wraparound Report is used to provide summary data for LTC recipients for services provided in all places of service, excluding drug details. This report is useful in identifying services provided by different providers that are similar or duplicative and assist in the review of the quality of care provided to Medicaid recipients.

Sort Sequence

Facility/provider number, RID, provider type, attending provider number, and from date of service

Distribution

Distribution	Media	Copies	Frequency
EDS	CRLD		Quarterly
IFSSA	CRLD		Quarterly

Long Term Care Summary Detail Non-Drug Wraparound

Part II Report Definition Information

Functional Area: SURS

Report Number: SUR-0634-Q

Detailed Field Definitions

Table 6.63 – Field Description

Field	Description
Period	The period for the data extracted and summarized on this report.
Prov	The nursing home identification number.
Name	The nursing home name.
Address	The nursing home address.
Spec	The provider specialty code.
Location	The provider location code.
RID	Recipient identification number.
Name	Recipient last name, first name.
Address	Recipient address.
Age	The recipient's age at the date of service.
Type	The provider type code.
Att Pr	The attending provider number.
FDOS	The beginning date of service on the claim detail MM/DD/CCYY date format.
TDOS	The end date of service on the claim detail MM/DD/CCYY date format.
Ts/Proc	The procedure code being reported.
Description	The procedure description.
Unit Svc	The units of service for the procedure.
Amt Billed	The amount billed for this detail.
Pd Amt	The amount paid for this detail.
Pct Tot Prov Pmt	The percent paid, calculated as follows: Amt Pd for this Detail Amt Pd for Entire Prov Type
Recipient Totals:	Totals for the recipient.
No Providers	The unduplicated provider count for the recipient.
Amt Billed	The total amount billed for this recipient.

Table 6.63 – Field Description

Field	Description
Amt Paid	The total amount paid for this recipient.

Report Example: Long Term Care Summary Detail Non-Drug Wraparound

```
  REPORT:   SUR-0634-Q                                 INDIANA AIM                                                    DATE: 10/23/00
 PROCESS:   DSIBMUL2                      LTC SUMMARY DETAIL NON-DRUG WRAPAROUND REPORT                               TIME: 14:01:33
LOCATION:   HUGP63WB                                 PERIOD: MM/YY THRU MM/YY                                         PAGE:        1

 PROV:        99999999         NAME XXXXXXXXXXXXXXXXXXXXXXXXXXXXXX   ADDRESS XXXXXXXXXXXXXXXXXXXXXXXXX      SPEC  999      LOCATION  99
 RID:       999999999999       NAME XXXXXXXXXXXXXXXXXXXXXXXXXXXXXX   ADDRESS XXXXXXXXXXXXXXXXXXXXXXXXX       AGE   99

      TYPE  999

         ATT PROV    99999999

                                                                                                                         PCT TOT
   FDOS      TDOS              TS/PROC                                     UNIT SVC       AMT BILLED          PD AMT      PROV PMT

MM/DD/CCYY MM/DD/CCYY          XXXXXX     XXXXXXXXXXXXXXXXXXXXXXXX           99999       999,999.99       999,999.99        999.99
MM/DD/CCYY MM/DD/CCYY          XXXXXX     XXXXXXXXXXXXXXXXXXXXXXXX           99999       999,999.99       999,999.99        999.99
MM/DD/CCYY MM/DD/CCYY          XXXXXX     XXXXXXXXXXXXXXXXXXXXXXXX           99999       999,999.99       999,999.99        999.99
MM/DD/CCYY MM/DD/CCYY          XXXXXX     XXXXXXXXXXXXXXXXXXXXXXXX           99999       999,999.99       999,999.99        999.99


   RECIPIENT TOTALS:           NO PROVIDERS  99,999       AMT BILLED -  99,999,999.99        AMT PAID -  99,999,999.99
```

Report Definition: SUR-0635-Q Long Term Care Summary Detail Drug Wraparound

Part I Report Definition Information

Functional Area: SURS

Report Number: SUR-0635-Q

Job Name: DSIBMUL2

Report Title: Long Term Care Summary Detail Drug Wraparound

Description of Information

The Long Term Care Summary Detail Drug Wraparound Report displays the recipient's total drug inpatient services provided to nursing home residents. The recipient detail includes hospital stay dates of service, National Drug Code, therapeutic class code, number of services performed for this recipient, amount billed for this recipient, and amount paid for the services given the recipient in this detail. The recipient totals are the number of providers the recipient has seen, the total amount billed for this recipient, and the total amount paid for this recipient. The report contains the same information as the LTC Summary Detail Drug Report but this report is sorted in facility number, recipient number, and then provider number order.

Purpose of Report

The Long Term Care Summary Detail Drug Wraparound Report is used to identify questionable drug treatments or prescribed regimens for LTC recipients regardless of place of service. Prescribing and supplying providers can be identified for further analysis.

Sort Sequence

Facility/provider number, RID, provider type, attending provider number, and from date of service

Distribution

Distribution	Media	Copies	Frequency
EDS	CRLD		Quarterly
IFSSA	CRLD		Quarterly

Long Term Care Summary Detail Drug Wraparound

Part II Report Definition Information

Functional Area: SURS

Report Number: SUR-0635-Q

Detailed Field Definitions

Table 6.64 – Field Description

Field	Description
Period	The period for the data extracted and summarized on this report.
Prov	The nursing home facility identification number.
Name	The nursing home name.
Address	The nursing home address.
Spec	The nursing home specialty code.
Location	The nursing home location code.
RID	Recipient identification number.
Name	Recipient last name, first name.
[Address]	Recipient address.
Age	The recipient's age at the date of service.
Type	The attending provider type code.
Att Prov	The attending provider number.
FDOS	The beginning date of service on the claim detail MM/DD/CCYY date format.
TDOS	The end date of service on the claim detail MM/DD/CCYY date format.
NDC	The National Drug Code and description.
Brand Cert	Brand certification code. The recipient should receive generic drugs unless a physician authorizes a brand name drug. 1 = brand name 2 = generic
Unit Svc	The units of service for the procedure.
Amt Billed	The amount billed for this detail.
Amt Pd	The amount paid for this detail.
Pct Tot Prov Pmt	The percent paid, calculated as follows: Amt Pd for this Detail Amt Pd for Entire Prov Type

Table 6.64 – Field Description

Field	Description
Recipient Totals:	Totals for the recipient.
No Providers	The unduplicated attending provider count for the recipient.
Amt Billed	The total amount billed for this recipient.
Amt Paid	The total amount paid for this recipient.

Report Example: Long Term Care Summary Detail Drug Wraparound

```
 REPORT:    SUR-0635-Q                                   INDIANA AIM                                                 DATE: 10/23/00
PROCESS:    DSIBMUL2                          LTC SUMMARY DETAIL DRUG WRAPAROUND REPORT                              TIME: 14:01:33
LOCATION:   HUGP63WB                                PERIOD: MM/YY THRU MM/YY                                         PAGE:        1

 PROV:        99999999         NAME XXXXXXXXXXXXXXXXXXXXXXXXXXXXXX   ADDRESS XXXXXXXXXXXXXXXXXXXXXXXXX       SPEC  999      LOCATION  99
 RID:       999999999999       NAME XXXXXXXXXXXXXXXXXXXXXXXXXXXXXX   ADDRESS XXXXXXXXXXXXXXXXXXXXXXXXX        AGE   99

      TYPE  999

        ATT PROV    99999999
PCT TOT
FDOS       TDOS                 NDC                                 BRAND CERT    UNITS SVC      AMT BILLED         AMT PD     PROV PMT

MM/DD/CCYY MM/DD/CCYY           XXXXXXXXXXXXX  XXXXXXXXXXX              9            99999       999,999.99      999,999.99       999.99
MM/DD/CCYY MM/DD/CCYY           XXXXXXXXXXXXX  XXXXXXXXXXX              9            99999       999,999.99      999,999.99       999.99
MM/DD/CCYY MM/DD/CCYY           XXXXXXXXXXXXX  XXXXXXXXXXX              9            99999       999,999.99      999,999.99       999.99
MM/DD/CCYY MM/DD/CCYY           XXXXXXXXXXXXX  XXXXXXXXXXX              9            99999       999,999.99      999,999.99       999.99
MM/DD/CCYY MM/DD/CCYY           XXXXXXXXXXXXX  XXXXXXXXXXX              9            99999       999,999.99      999,999.99       999.99
MM/DD/CCYY MM/DD/CCYY           XXXXXXXXXXXXX  XXXXXXXXXXX              9            99999       999,999.99      999,999.99       999.99
MM/DD/CCYY MM/DD/CCYY           XXXXXXXXXXXXX  XXXXXXXXXXX              9            99999       999,999.99      999,999.99       999.99
MM/DD/CCYY MM/DD/CCYY           XXXXXXXXXXXXX  XXXXXXXXXXX              9            99999       999,999.99      999,999.99       999.99
MM/DD/CCYY MM/DD/CCYY           XXXXXXXXXXXXX  XXXXXXXXXXX              9            99999       999,999.99      999,999.99       999.99
MM/DD/CCYY MM/DD/CCYY           XXXXXXXXXXXXX  XXXXXXXXXXX              9            99999       999,999.99      999,999.99       999.99
MM/DD/CCYY MM/DD/CCYY           XXXXXXXXXXXXX  XXXXXXXXXXX              9            99999       999,999.99      999,999.99       999.99


   RECIPIENT TOTALS:           NO PROVIDERS  99,999        AMT BILLED -  99,999,999.99         AMT PAID -  99,999,999.99
```

Report Definition: SUR-0636-Q Long Term Care Summary Detail Combined Wraparound

Part I Report Definition Information

Functional Area: SURS

Report Number: SUR-0636-Q

Job Name: DSIBMUL2

Report Title: Long Term Care Summary Detail Combined Wraparound

Description of Information

The Long Term Care Summary Detail Combined Wraparound Report displays the recipient's total non drug and drug ambulatory and inpatient services provided to nursing home residents. The recipient detail includes hospital stay dates of service, procedure or National Drug Code, therapeutic class code, number of services performed for this recipient, amount billed for this recipient, and amount paid for the services given the recipient in this detail. The recipient totals are the number of providers the recipient has seen, the total amount billed for this recipient, and the total amount paid for this recipient. The report contains the same information as the LTC Summary Detail Combined Report but this report is sorted in facility number, recipient number, and then provider number order.

Purpose of Report

The Long Term Care Summary Detail Combined Wraparound Report is used to provide a comprehensive or global review of care provided and services rendered to LTC recipients. Aberrant provider practice patterns within a LTC facility and for specific residents can be identified and documented by the user.

Sort Sequence

Facility/provider number, RID, provider type, attending provider number, and from date of service

Distribution

Distribution	Media	Copies	Frequency
EDS	CRLD		Quarterly
IFSSA	CRLD		Quarterly

Long Term Care Summary Detail Combined Wraparound

Part II Report Definition Information

Functional Area: SURS

Report Number: SUR-0636-Q

Detailed Field Definitions

Table 6.65 – Field Description

Field	Description
Period	The period for the data extracted and summarized on this report.
Prov	The nursing home facility identification number.
Name	The nursing home name.
Address	The nursing home address.
Spec	The provider specialty code.
Location	The nursing home/provider location code.
RID	Recipient identification number.
Name	Recipient last name, first name.
Address	Recipient address.
Age	The recipient's age at the date of service.
Type	The provider type code.
Att Pr	The attending provider number.
FDOS	The beginning date of service on the claim detail MM/DD/CCYY date format.
TDOS	The end date of service on the claim detail MM/DD/CCYY date format.
Ts/Proc	The procedure code and description, or the National Drug
NDC	Code and description.
Brand Cert	This field contains the brand certification code, when applicable. The recipient should receive generic drugs unless a physician authorizes a brand name drug. 1 = brand name 2 = generic
Unit Svc	The units of service for the procedure.
Amt Billed	The amount billed for this detail.
Amt Pd	The amount paid for this detail.
Pct Tot Prov Pmt	The percent paid, calculated as follows: Amt Pd for this Detail Amt Pd for Entire Prov Type

Table 6.65 – Field Description

Field	Description
Recipient Totals:	Totals for the recipient.
No Providers	The unduplicated attending provider count for the recipient.
Amt Billed	The total amount billed for this recipient.
Amt Paid	The total amount paid for this recipient.

Report Example: Long Term Care Summary Detail Combined Wraparound

```
  REPORT:   SUR-0636-Q                                 INDIANA AIM                                       DATE: 10/23/00
 PROCESS:   DSIBMUL2                   LTC SUMMARY DETAIL COMBINED WRAPAROUND REPORT                     TIME: 14:01:33
LOCATION:   HUGP63WB                              PERIOD: MM/YY THRU MM/YY                               PAGE:       1

 PROV:        99999999        NAME XXXXXXXXXXXXXXXXXXXXXXXXXXXXXX   ADDRESS XXXXXXXXXXXXXXXXXXXXXXXXX     SPEC  999      LOCATION  99
 RID:       999999999999      NAME XXXXXXXXXXXXXXXXXXXXXXXXXXXXXX   ADDRESS XXXXXXXXXXXXXXXXXXXXXXXXX      AGE   99

      TYPE  999

        ATT PROV    99999999
                                                                                                                       PCT TOT
FDOS       TDOS                NDC                                  BRAND CERT    UNITS SVC       AMT BILLED          AMT PD     PROV PMT

MM/DD/CCYY MM/DD/CCYY          XXXXXXXXXXXXX  XXXXXXXXXXX              9              99999      999,999.99      999,999.99       999.99
MM/DD/CCYY MM/DD/CCYY          XXXXXXXXXXXXX  XXXXXXXXXXX              9              99999      999,999.99      999,999.99       999.99
MM/DD/CCYY MM/DD/CCYY          XXXXXXXXXXXXX  XXXXXXXXXXX              9              99999      999,999.99      999,999.99       999.99
MM/DD/CCYY MM/DD/CCYY          XXXXXXXXXXXXX  XXXXXXXXXXX              9              99999      999,999.99      999,999.99       999.99
MM/DD/CCYY MM/DD/CCYY          XXXXXXXXXXXXX  XXXXXXXXXXX              9              99999      999,999.99      999,999.99       999.99
MM/DD/CCYY MM/DD/CCYY          XXXXXXXXXXXXX  XXXXXXXXXXX              9              99999      999,999.99      999,999.99       999.99
MM/DD/CCYY MM/DD/CCYY          XXXXXXXXXXXXX  XXXXXXXXXXX              9              99999      999,999.99      999,999.99       999.99
MM/DD/CCYY MM/DD/CCYY          XXXXXXXXXXXXX  XXXXXXXXXXX              9              99999      999,999.99      999,999.99       999.99
MM/DD/CCYY MM/DD/CCYY          XXXXXXXXXXXXX  XXXXXXXXXXX              9              99999      999,999.99      999,999.99       999.99
MM/DD/CCYY MM/DD/CCYY          XXXXXXXXXXXXX  XXXXXXXXXXX              9              99999      999,999.99      999,999.99       999.99
MM/DD/CCYY MM/DD/CCYY          XXXXXXXXXXXXX  XXXXXXXXXXX              9              99999      999,999.99      999,999.99       999.99

    RECIPIENT TOTALS:          NO PROVIDERS  99,999       AMT BILLED -  99,999,999.99         AMT PAID -  99,999,999.99
```

Section 7: Report Generation Control Files

The numerous options which make the RAM II function so flexible are, for the most part, controlled and maintained by the user. This section will discuss the purpose and the method for maintaining these control files. The categories of control files are:

- Cycle Control Data and Customer Options File (10 Control File) - This control file is reviewed prior to each quarterly cycle to determine which reports to produce, date ranges, date types, reporting minimums, etc.

- Cross-reference File (20 Control File) - This file controls peer grouping for providers and recipients. It also controls cross-reference groupings of diagnosis and procedure codes for the Treatment Analysis Subsystem.

- Selected Provider and Recipient File (30/60 Control File) - These files control which reports are automatically produced on hard copy for selected providers and recipients during the quarterly run.

- Summary Profile Line Item Control File (40 Control File) - This file controls the data to be reported in the provider and recipient summary profile subsystems.

- LTC Select File (50 Control File) - This file allows the user to select certain providers for processing in the nursing home reporting system.

- DRG Control Members - These TSO members control the peer grouping, cross-referencing and mean length of stay reference for the DRG reports.

- Deselection of Providers and/or Recipients (70 Control File) - This file allows the user to eliminate certain providers and/or recipients from exception processing.

Account Cycle Control Data and Customer Options Control

The Account Cycle Control Data and Customer Options Control Report and SUR Options and Options Dates Windows provide the user with a status report on the manner in which the current cycle is to be run. The report is broken down into various segments reflecting information, data, and options in all areas of a utilization review cycle.

Decisions involving modifications to the cycle controls should always be the result of a combination of:

- Customer interface - recognizing and analyzing the customer's needs.

- Support interface - to aid in analyzing and defining the effects of any system option selections or changes.

The Options Report and SUR Options and Option Dates Windows contain many self-explanatory line items and some which may not be so readily apparent. Following this introduction are examples of the windows used for option control, with corresponding field descriptions, and an option by option definition table to aid in understanding the choices available.

A quarterly meeting is held with the customer to discuss and approve system modifications for the quarterly SUR report production. When all parties involved are satisfied with the selections, the customer will initial and date the report in the space provided, approving the scheduled production of the quarterly SUR reports.

The many options available to the user allow for virtually a "tailor made" system to user specifications. Again, all ramifications of changes to cycle controls must be thought through with all user representatives and system support prior to initiation.

- Base File System Data - Options in the Base File System Data segment relate to the current quarter's data base.

- General System Data - Options in the General System Data segment pertain, for the most part, to system-wide options defined to meet the particular customer's needs.

- Monthly System Data - Options in the Monthly System Data segment pertain to the monthly extract, provider file, history details and Distribution reporting.

- Treatment Analysis Data - Options in the Treatment Analysis System Data segment pertain to the treatment analysis processing and reporting variables.

- Recipient Summary - Options in the Recipient Summary System segment pertain to the recipient summary series reports.

- Provider Summary - Options in the Provider Summary System segment pertain to the provider summary series reports.

- Special Subsystems - Options in the Special Subsystems Data segment pertain to options available for any "special" reporting that Indiana generates that is not included in the "base" RAMS II function.

Report Definition: SRGR010 Account Cycle Control Data and Customer Options Control Report

Part I Report Definition Information

Functional Area:	SURS
Report Number:	SRGR010
Report Title:	Account Cycle Control Data and Customer Options Control Report

Description of Information

The Account Cycle Control Data and Customer Options Control Report provides the user with a status report on the manner in which the current cycle is to be generated. The report is broken down into various segments reflecting information, data, and options in all areas of a utilization review cycle.

Table 7.1 – User Option

Option	Description
General System Data	Options in the General System Data segment pertain, for the most part, to system-wide options defined to meet the particular customer's needs.
Base File System Data	Options in the Base File System Data segment relate to the current quarter's data base.
Monthly System Data	Options in the Monthly System Data segment pertain to Distribution the monthly extract, provider file, history details and reporting.
Treatment Analysis Data	Options in the treatment Analysis System Data segment pertain to the treatment analysis processing and reporting variables.
Recipient Summary	Options in the Recipient Summary System segment pertain to the recipient summary series reports.
Provider Summary	Options in the Provider Summary System segment pertain to the provider summary series reports.
Special Subsystems	Options in the Special Subsystems Data segment pertain to options available for any "special" reporting that Indiana generates that is not included in the "base" RAMS II function.

Purpose of Report

The Cycle Control Data and Customer Options Control File is reviewed prior to each quarterly cycle to determine which reports to produce, date ranges, date types, reporting minimums, etc.

Sort Sequence

Segment, Option number

Distribution

Distribution	Media	Copies	Frequency
IFSSA	Paper	1 copy	Quarterly

Account Cycle Control Data and Customer Options Control

Part II Report Definition Information

Functional Area: SURS

Report Number: SRGR010

Detailed Field Definitions

Table 7.2 – Field Description

Field	Description
[Option Designation]	**OPTION** printed in this field identifies the report generation specification as an option, to be controlled by the user. 'Blank' printed in this field identifies the report generation specification as a system controlled parameter.
[Option Specification]	A brief description of the cycle generation control option.
[Option Selection]	The option selected by the user, or controlled by the system for the Option Specification.
Customer Approval	A space provided for customer approval of system control specifications.
Date	A space provided for customer date of approval of system control specifications.

Report Example: Account Cycle Control Data and Customer Options Control

```
SRGR010                              INDIANA MEDICAID MANAGEMENT INFORMATION SYSTEM                              PAGE 99,999

RUN DATE: MM/DD/CCYY                ACCOUNT CYCLE CONTROL DATA AND CUSTOMER OPTIONS REPORT         PERIOD: MM/CCYY THRU MM/CCYY

PROGRAM: MEDICAID

                                                  ***  GENERAL SYSTEM DATA   ***

** OPTION **    77) PLACE OF SERVICE  42  DESCRIPTION  IS . . . . . . . . . . . . . . . . . . . . . .AIRAMBULANCE
** OPTION **    78) PLACE OF SERVICE  51  DESCRIPTION  IS . . . . . . . . . . . . . . . . . . . . .COMMMNTLHLTHCT
** OPTION **    79) PLACE OF SERVICE  54  DESCRIPTION  IS . . . . . . . . . . . . . . . . . . . . . . . . ICFMR
** OPTION **    80) PLACE OF SERVICE  55  DESCRIPTION  IS . . . . . . . . . . . . . . . . . . . . .RESSUBABUSETXF
** OPTION **    81) PLACE OF SERVICE  56  DESCRIPTION  IS . . . . . . . . . . . . . . . . . . . . . PSYCHRESTXCTR
** OPTION **    82) PLACE OF SERVICE  61  DESCRIPTION  IS . . . . . . . . . . . . . . . . . . . . . COMPINPTRHABF
** OPTION **    83) PLACE OF SERVICE  62  DESCRIPTION  IS . . . . . . . . . . . . . . . . . . . . .COMPOUTPRHAB
** OPTION **    84) PLACE OF SERVICE  65  DESCRIPTION  IS . . . . . . . . . . . . . . . . . . . . .ESRDTXFACILITY
** OPTION **    85) PLACE OF SERVICE  71  DESCRIPTION  IS . . . . . . . . . . . . . . . . . . . . .PUBLICHEALTHCL
** OPTION **    86) PLACE OF SERVICE  72  DESCRIPTION  IS . . . . . . . . . . . . . . . . . . . . . . . . . RHC
** OPTION **    87) PLACE OF SERVICE  81  DESCRIPTION  IS . . . . . . . . . . . . . . . . . . . . . . . . . LAB
** OPTION **    88) PLACE OF SERVICE  99  DESCRIPTION  IS . . . . . . . . . . . . . . . . . . . . OTHERUNLISTED
** OPTION **    89) TREATMENT ANALYSIS SUBSYSTEM FOR THIS CYCLE IS . . . . . . . . . . . . . . . . . . . . . . ON
** OPTION **    90) RECIPIENT SUMMARY SUBSYSTEM FOR THIS CYCLE IS. . . . . . . . . . . . . . . . . . . . . .ON
** OPTION **    91) PROVIDER SUMMARY SUBSYSTEM FOR THIS CYCLE IS. . . . . . . . . . . . . . . . . . . . . .ON



                                                CUSTOMER APPROVAL BY _____________________________  DATE ___________
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Cross Reference Control

The Cross-Reference Control Reports and Windows provide the user with a method for evaluating and cross-referencing smaller components of peer groups and treatment classifications to a broader designation for the purpose of establishing statistically sound comparison groupings in relation to population experience.

The extent of cross-referencing is based on the volume of Medicaid activity within the state (the number of providers, recipients), and the structure of the detail coding. Any or all of the categories that follow can be assigned cross-reference values, processed as original values, or combined with a designation of "all" for processing and reporting.

The cross-reference scheme is completely at the discretion of the user. Preliminary research regarding peer group criteria population and Medicaid claim activity volume prior to establishing cross-referencing schemes is imperative in establishing cross-reference grouping of statistical significance. Cross-referencing established at too detailed a level can produce base norms that are indicative of only a few 'dominant cases' rather than the population's customary experience.

Provider Peer Groups

Peer groups for provider processing and reporting are based on 7 criteria: category of service, provider type, provider primary specialty, geographic region (locality), type of practice/organization, billing vs. performing status and bed size (institutional providers). A different peer group strategy can be used for each category of service. Note that category of service, type of practice/organization and billing vs. performing status, as peer grouping options, are defined and controlled in the Account Cycle Control Data and Customer Options and are not included for cross-reference value designation.

Category of Service

Categories of service provide separation of the basic kinds of services provided in the medical assistance program. The different categories of service used not only separate the different kinds of services, but also provide the broadest segregation of providers in the system for realistic exception processing. Provider peer groups will be further defined within each category of service by other, more detailed, peer grouping criteria.

Categories of service are defined by provider specialty/type combinations. In some cases, such as Inpatient and Outpatient, claim type must also be part of the definition.

Once the categories of service have been defined, they should not be changed unless absolutely necessary. If a change to the category of service scheme is unavoidable, the Phase II treatment analysis base must be generated.

Provider Type Cross-Reference

The purpose of establishing cross-reference groupings for provider type is to group providers who perform similar types of services in order to establish a realistic data base for treatment and practice comparison. Following preliminary evaluation of each type value's population, types can be grouped for balanced distribution.

An example of a commonly used type cross-reference designation may be to combine MDs and DOs, creating a broader base titled "Physician".

Provider Specialty Cross-Reference

The purpose of establishing cross-reference groupings for provider specialty is to further classify providers within the broad-based Type designations by segregating providers whose recipient treatment or service delivery is expected to reflect similar patterns due to the limitations and focus of their specialty. A combination of research regarding each specialty values population and scope of practice is essential in grouping specialties to establish a statistically sound base of related practice patterns.

Specialties whose population is limited and practice patterns have similarity, such as Neurological Surgery, Orthopedic Surgery, Plastic Surgery, Hand Surgery, Thoracic Surgery are commonly grouped together to form a more general classification, such as 'Surgery'.

Provider Bedsize Cross-Reference

Bedsize used as a peer grouping criteria for institutional provider types is established at the time of system definition. Cross-referencing of bedsize groupings is accomplished through use of the specialty cross-reference function. If the system is defined to peer group by bedsize for institutional provider types, bedsize values are utilized as values on the specialty cross-reference file for institutional categories of service.

Provider Geographic Region Cross-Reference

Geographical region, or locality, cross-referencing is established for each category of service. Locality cross-reference designation is formed with consideration regarding population, pricing, natural demographics and administrative regions.

Recipient Peer Groups

Peer groups for recipient processing and reporting are based on 7 criteria: age, sex, race, living arrangement/LTC indicator, geographic region, aid category and agency origin/special programs indicator. Note that only geographic region and aid category are broad enough based classifications to warrant cross-reference capabilities. The remaining peer grouping criteria are defined and controlled in the Account Cycle Control Data and Customer Options.

Recipient Aid Category Cross-Reference

Recipient aid categories that are not adequately populated and that experience similar medical activity can be grouped to form an adequate data base for establishing norms and making comparisons. Conversely, the option exists to force all recipients of a particular aid category into one statewide locality. This enables the user to split larger aid groups, such as AFDC, into several localities while combining the recipients in small aid categories into one locality.

Recipient Geographic Region Cross-Reference

Population and natural demographics are the two major considerations when utilizing geographic region, or locality, as a recipient peer grouping criteria. The recipient population in the regions established should be as evenly distributed as possible and adequate enough to produce meaningful norms and comparisons.

Treatment Analysis Criteria

Procedures and diagnoses can be cross-referenced and grouped for ease and effectiveness of treatment analysis reporting. In order to estimate the relative volume of each diagnosis and procedure prior to establishing a cross-reference scheme, the Phase I Code Distribution Reports should be generated. The analysis of these reports will support the creation of these two cross-reference tables. Treatment analysis processing criteria, including cross-reference scheme, can only be changed at the time of Phase II production. Only during Phase II are treatment norms calculated and established to be used in quarterly Phase III production.

Diagnosis Cross-Reference

Categories of related diagnosis codes are established to create an adequate data base for realistic treatment analysis and exception reporting. It may be useful when determining these categories, to use the same general categories outlined in the International Classification of Diseases, Volume I. The codes assigned to the related classes of diseases are within numeric ranges which can be used as the basis of the diagnosis categories. A Diagnosis Code Summary and Rank Report by Diagnosis Code, produced in Phase I, will indicate the number of services for each code. When utilizing the Diagnosis Code Summary for this purpose, only those categories of service used for Treatment Analysis should be considered. Depending on the volume of activity within each range, it may be desirable to combine certain diagnosis groups or to further define others. For instance, pneumonia could be classified under respiratory disorders if the number of services for pneumonia was low; if the number of services was high, it could be established as a separate category. State specific, administrative diagnoses which were created for special applications in the state should also be included in these cross-reference tables. Non-valid diagnosis codes which have passed through the system erroneously will be reported under cross-reference value "other" unless their value falls within a valid range. Following this concept, a table such as the one below can be developed.

Table 7.3 – Sample Diagnosis Cross-Reference

X-Ref Value	X-Ref Description	Detail Codes	Detail Description
X1010	Infectious/Parasitic Gastroenteritis	00100	Cholera
		04190	Bacterial Infection NOS
X0420	HIV	04200	HIV w/specified conditions
		04490	HIV NOS
X0520	Viral Disease	05200-	Chickenpox
		07990	Viral Disease NOS
X2500	Diabetes Mellitus (Non-insulin)	25000-	Diabetes, Adult
		25000	Diabetes, Adult

Note that Diabetes was separated from its general class due to service volume of the diagnosis. The Phase I Diagnosis Code Summary and Rank Report, sorted by number of services, will identify the top "X" number of diagnoses, which the user may want to separate from their general categories due to the high number of services. A diagnosis cross-reference table can be as general or as detailed as the user specifies to support the use of the resulting reports.

Procedure Cross-Reference

Related procedure codes are grouped in the same manner as diagnoses, and for the same reasons; to create a base of data which is manageable in size and upon which statistically valid comparisons may be calculated for treatment analysis reporting. The general categories of procedure codes in most procedure coding schemes are:

1. Medicine
2. Anesthesia
3. Surgery
4. Radiology
5. Pathology

Within these major categories there are many obvious subcategories which should be used. Following is an example of how a procedure cross-reference table may be arranged:

Table 7.4 – Sample Procedure Cross-Reference

X-Ref Value	X-Ref Description	Detail Codes	Detail Description
X1000	Surgery, Integumentary System	10040-	Acne surgery
		19499	Unlisted procedure, breast
X2000	Surgery, Musculoskeletal System	20000-	Incision of soft tissue abscess
		29909	Unlisted procedure, arthroscopy
X3000	Surgery, Respiratory System	30000-	Drainage abscess or hematoma
		32999	Unlisted procedure, lungs/pleura
X3300	Surgery, Cardiovascular System	33010-	Pericardiocentesis; initial
		37799	Unlisted procedure, vascular
X5640	Surgery, Female Genital System	56405-	Incision & drainage of vulva
		58999	Unlisted procedure, female genital (non-OB)
X5900	Surgery, Maternity Care & Delivery	59000-	Amniocentesis, any method
		59899	Unlisted procedure, maternity care & delivery

A Phase I Procedure Code Distribution and Statistical Analysis Report, sorted by number of services, will identify the most frequently used procedures. This report can be used to determine which procedures should be reported separately from their general classifications. For example, Maternity

Care and Delivery Surgical procedures (a sub category of Female Genital System Surgical procedures) present a sufficient base, are unique in treatment, and upon which comparisons may be based with statistical confidence. If desired, the sub category of Maternity Care & Delivery can be further broken down by vaginal delivery and Cesarean section delivery for more specific treatment comparisons. The procedure cross-reference table established by the user can be as general or as detailed as appropriate for the Medicaid volume.

Maintenance of Cross-Reference Files

The method for cross-referencing in RAMS II allows the user flexibility in establishing provider and beneficiary peer groups, diagnosis categories and procedure categories.

Some features within the system are:

- Cross-reference locality to Statewide for categories of service with a limited number of providers such as Inpatient, Outpatient and Long Term Care.

- Only those provider types and specialties which apply to a category of service need to be included in each cross-reference table. Therefore, any miscellaneous types or specialties which occur in a category of service erroneously will be assigned to the default value and can be easily identified.

- Only those procedures which should occur within a category of service need to be assigned to a cross-reference value. Any miscellaneous codes which are encountered in a category of service will be assigned to the cross-reference value which has been selected a default.

- Diagnosis codes can be cross-referenced as most appropriate for each category of service processed through the Treatment Analysis.

- The capability is available to "force" selected provider specialties, case mix codes, or recipient aid categories into one geographic region, while allowing the others to peer according to their actual locality. This allows the user to cross-reference small peer groups into one larger statewide group; thereby establishing an adequate data base for the small, but unique, provider or recipient groups.

A "master file" is created and maintained, which will contain the cross-reference information for use in SURS processing. The following criteria will be included on the file.

For each category of service:

- Provider Locality

- Provider Type

- Provider Specialty

- Provider Bedsize

For Recipients:

- Recipient Aid Category
- Recipient Locality

For Categories of Service processed through Treatment Analysis:

- Diagnoses
- Procedures

Four types of input are defined for each cross-reference category:

- Type A - provides a cross-reference default value for any detail code which was not assigned to a cross-reference code with a Type C input. Only one default value can be assigned per cross-reference category.
- Type B - provides a description for each different cross-reference code used in either Type A or Type C input.
- Type C - assigns detail codes to a cross-reference value. Detail code ranges can be established by coding the "from" and "to" value.
- Type D - provides descriptions for the detail codes used in Type C inputs. Detail codes which occur in more than one category of service should be entered with a description only once.

The cross-reference control file is input through on-line screens. As the files are built, on-line editing is performed to detect format or coding errors. Once all inputs have been entered for a cross-reference category, they are processed through another edit routine that performs relationship edits between the inputs. If no errors are detected, the cross-reference control file is built and cross reference reports are produced. If errors are detected, edit reports will be produced which identify the errors for correction.

Examples of the window used for cross-reference criteria input, and the resulting Cross-Reference Edit Reports generated follow, with corresponding field descriptions of each.

Window Definition: UMR Cross-Reference

Introduction

The Cross-Reference Control File controls peer grouping for providers and recipients, and also controls cross-reference groupings of diagnosis and procedure codes for the Treatment Analysis function.

The UMR Cross Reference Window is used to gain access to the following functions:

Update a cross reference scheme for SUR reporting

View a Utilization Review cycle's cross-reference tables

The UMR Cross Reference Window will be accessed utilizing the mouse by clicking the Cross Reference (20 File) button on the SUR Main Menu. The window may be accessed using the keyboard by pressing the underscored letter/number of the SUR Main Menu button.

Detailed Field Information

Table 7.5 Field Description

Field	Description
FIELD NAME:	CROSS REFERENCE CRITERIA
DESCRIPTION:	The reporting criteria to be cross referenced
FORMAT:	Provider Locality Provider Type Provider Specialty Recipient Aid Category Recipient Locality Diagnosis Procedure
FEATURES:	Drop down list box
EDITS:	None
TO CORRECT:	N/A
FIELD NAME:	Cat of Service
DESCRIPTION:	The category of service to which cross referencing will be applied
FORMAT:	00 UNUSED 01 INPATIENT 03 OUTPATIENT 04 PCCM 05 RBMC 06 PHYSICIAN 07 PHARMACY 08 SUPPLIERS 11 LAB/XRAY/SPLT. CLINIC 13 TRANSPORTATION/SP SVC 14 LONG TERM CARE 20 THERAPY SERVICES 22 MENTAL HEALTH 23 DENTAL/OPTOMETRIC 33 WAIVER PROGRAMS
FEATURES:	Drop down list box

Table 7.5 Field Description

Field	Description
EDITS:	80022 - Select the cross-reference type before COS
TO CORRECT:	Select the cross-reference criteria
EDITS:	80023 - No records for selected XREF and COS choice
TO CORRECT:	Select a valid, existing cross reference and category combination, or create records for the cross reference and category selected
FIELD NAME:	TOTAL RECORDS
DESCRIPTION:	The total number of C cards on file for the cross reference criteria and category of service selected
FORMAT:	4 digit numeric
FEATURES:	System generated
EDITS:	None
TO CORRECT:	N/A
FIELD NAME:	Low Range
DESCRIPTION:	The original from value in a range of original values for the cross reference criteria selected
FORMAT:	7 digit alpha/numeric
FEATURES:	None
EDITS:	91006 - Field is required
TO CORRECT:	Key low range 80024 - C card must have corresponding D card
TO CORRECT:	Key a corresponding D card Invalid range, range already exists
TO CORRECT:	Delete duplicate range
FIELD NAME:	High Range
DESCRIPTION:	The original to value in a range of original values for the cross reference criteria selected
FORMAT:	7 digit alpha/numeric
FEATURES:	None
EDITS:	91006 - Field is required.
TO CORRECT:	Key a high range 80024 - C card must have corresponding D card
TO CORRECT:	Key a corresponding D card 80009 - Invalid range, low range > high range
TO CORRECT:	Verify and key high range > low range 80011 - You have keyed in an overlapping range!
TO CORRECT:	Delete duplicate range
FIELD NAME:	Xref Value

Table 7.5 Field Description

Field	Description
DESCRIPTION:	The cross reference value to which the associated original values will be assigned
FORMAT:	7 digit alpha/numeric
FEATURES:	None
EDITS:	80026 - C card must have corresponding B card
TO CORRECT:	Key a corresponding B card 91006 - Field is required
TO CORRECT:	Key an xref value

Other messages / edits

- "Save successful" - Save button
- "Save unsuccessful" - Save button
- "Delete successful" - Delete button
- "Delete unsuccessful" - Delete button
- "Continue without saving?" - Exit button

Report Definition: SRGR022-E Provider Type Cross-Reference Edit

Part I Report Definition Information

Functional Area:	SURS
Report Number:	SRGR022-E
Job Name:	SRGJQ020
Report Title:	Provider Type Cross-Reference Edit Report

Description of Information

The Provider Type Cross-Reference Edit Report displays data keyed into the Provider Type Cross-Reference Control File and error messages for any formatting or relationship errors that may have occurred during input.

Purpose of Report

The Provider Type Cross-Reference Edit Report provides a means to verify that the data entered in the Provider Type Cross-Reference Control File is correct in format. When edit messages indicate errors have occurred, the incorrect data should be corrected and resubmitted for editing until no errors are identified.

Sort Sequence

As input

Distribution

Distribution	Media	Copies	Frequency
EDS	Paper	1 copy	On Request

Provider Type Cross-Reference Edit

Part II Report Definition Information

Functional Area: SURS

Report Number: SRGR022-E

Detailed Field Definitions

Table 7.6 – Field Description

Field	Description
AC LB	Account line of business code. IN indicates Indiana and 9 is for Medicaid
CD ID	Card, or input, identification code. Valid values are PTD if TP equal D and PTX if TP equal A, B, or C
CS	Category of service.
TY XF	Provider type cross-reference code assigned to the detail code.
TP	Card, or input type. Valid values are A, B, C, or D
Type Description	The provider type description as keyed on input types B and D.
From	The low code in a range of codes assigned to the cross-reference value as keyed on input type A and C.
To	The high code in a range of codes assigned to the cross-reference value as keyed on input type A and C.
Edit Message	Message indicates if any error was found and the nature of the error.

Table 7.7 – Footings

Field	Description
Cards Read	The number of inputs acknowledged by the system.
Cards Accepted	The number of inputs that passed all edits.
Cards Rejected	The number of inputs that failed one or more edits.
Total Records Written	The total number of records that were generated as a result of error-free inputs.
Total Masters Displaced	The total number of master records displaced.
Total Warning Messages	The number of warning messages displayed on the edit report.

If no errors were encountered in the report, a message "File Was Created" appears. Otherwise, the message "File Was Not Created" is printed, indicating that the user must correct the errors before the file will be created for cycle generation.

Report Example: Provider Type Cross-Reference Edit

```
SRGR022 -E                          INDIANA MEDICAID MANAGEMENT INFORMATION SYSTEM                                PAGE 99,999

RUN DATE: MM/DD/CCYY                 PROVIDER TYPE CROSS-REFERENCE EDIT REPORT                  PERIOD: MM/CCYY THRU MM/CCYY

-----------------------------------CARD IMAGE-----------------------------------

AC CD C TY     T LOCALITY DESCRIPTION/                                  ------------------ EDIT MESSAGE ------------------
LB ID S XF     P FROM     TO

IN9PTD  01     D Hospital                                                 PL23-DETAIL DESCRIPTION ACCEPTED

IN9PTD  01     D Ambulatory Surgical Center                               PL23-DETAIL DESCRIPTION ACCEPTED

IN9PTD  01     D Extended Care Facilities                                 PL23-DETAIL DESCRIPTION ACCEPTED

IN9PTD  01     D Rehabiliation Facility                                   PL23-DETAIL DESCRIPTION ACCEPTED

IN9PTD  01     D Home Health Agency                                       PL23-DETAIL DESCRIPTION ACCEPTED

IN9PTD  01     D Hospice                                                  PL23-DETAIL DESCRIPTION ACCEPTED

IN9PTD  01     D Capitation Provider                                      PL23-DETAIL DESCRIPTION ACCEPTED

IN9PTD  01     D Clinic                                                   PL23-DETAIL DESCRIPTION ACCEPTED

IN9PTD  01     D Advance Practice Nurse                                   PL23-DETAIL DESCRIPTION ACCEPTED
```

CUSTOMER APPROVAL BY _____ DATE _____

Report Definition: SRGR023-E Provider Specialty Cross-Reference Edit

Part I Report Definition Information

Functional Area:	SURS
Report Number:	SRGR023-E
Job Name:	SRGJQ020
Report Title:	Provider Specialty Cross-Reference Edit Report

Description of Information

The Provider Specialty Cross-Reference Edit Report displays data keyed into the Provider Specialty Cross-Reference Control File and error messages for any formatting or relationship errors that may have occurred during input.

Purpose of Report

The Provider Specialty Cross-Reference Edit Report provides a means to verify that the data entered in the Provider Specialty Cross-Reference Control File is correct in format. When edit messages indicate errors have occurred, the incorrect data should be corrected and resubmitted for editing until no errors are identified.

Sort Sequence

As input

Distribution

Distribution	Media	Copies	Frequency
EDS	Paper	1 copy	On Request

Provider Specialty Cross-Reference Edit

Part II Report Definition Information

Functional Area: SURS

Report Number: SRGR023-E

Detailed Field Definitions

Table 7.8 – Field Description

Field	Description
AC LB	Account line of business code. IN indicates Indiana and 9 is for Medicaid
CD ID	Card, or input, identification code. Valid values are PSD if TP equal D and PSX if TP equal A, B, or C.
CS	Category of service.
SP XF	Provider specialty cross-reference code assigned to the detail code.
TP	Card, or input type.
Specialty Description	The provider specialty description as keyed on input types B and D.
From	The low code in a range of codes assigned to the cross-reference value.
To	The high code in a range of codes assigned to the cross-reference value.
FCE LOC	Force locality indicator code.
Edit Message	Message indicates if any error was found and the nature of the error.

Table 7.9 – Footings

Field	Description
Cards Read	The number of inputs acknowledged by the system.
Cards Accepted	The number of inputs that passed all edits.
Cards Rejected	The number of inputs that failed one or more edits.
Total Records Written	The total number of records that were generated as a result of error-free inputs.
Total Masters Displaced	The total number of master records displaced.
Total Warning Messages	The number of warning messages displayed on the edit report.

If no errors were encountered in the report, a message "File Was Created" appears. Otherwise, the message "File Was Not Created" is printed, indicating that the user must correct the errors before the file will be created for cycle generation.

Report Example: Provider Specialty Cross-Reference Edit

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SRGR023 -E                          INDIANA MEDICAID MANAGEMENT INFORMATION SYSTEM                                PAGE 99,999

RUN DATE: MM/DD/CCYY                 PROVIDER SPECIALTY CROSS-REFERENCE EDIT REPORT               PERIOD: MM/CCYY THRU MM/CCYY

-----------------------------------CARD IMAGE-----------------------------------

AC CD C SP     T LOCALITY DESCRIPTION/         FCE                          ------------------ EDIT MESSAGE ------------------
LB ID S XF     P FROM     TO                   LOC

IN9PSD  010    D ACUTE CARE HOSPITAL                                       PS23-DETAIL DESCRIPTION ACCEPTED

IN9PSD  010    D PSYCHIATRIC HOSPITAL                                      PS23-DETAIL DESCRIPTION ACCEPTED

IN9PSD  010    D REHABILITATION HOSPITAL                                   PS23-DETAIL DESCRIPTION ACCEPTED

IN9PSD  010    D AMBULATORY SURGICAL HOSPITAL                              PS23-DETAIL DESCRIPTION ACCEPTED

IN9PSD  010    D NURSING FACILITIES                                        PS23-DETAIL DESCRIPTION ACCEPTED

IN9PSD  010    D ICF/MR                                                    PS23-DETAIL DESCRIPTION ACCEPTED

IN9PSD  010    D PEDIATRIC NURSING FACILITY                                PS23-DETAIL DESCRIPTION ACCEPTED

IN9PSD  010    D REHABILITATION FACILITY                                   PS23-DETAIL DESCRIPTION ACCEPTED

IN9PSD  010    D HOME HEALTH AGENCY                                        PS23-DETAIL DESCRIPTION ACCEPTED

                                                    CUSTOMER APPROVAL BY _____________________  DATE _________
```

Report Definition: SRGR021-E Provider Locality Cross-Reference Edit

Part I Report Definition Information

Functional Area:	SURS
Report Number:	SRGR021-E
Job Name:	SRGJQ020
Report Title:	Provider Locality Cross-Reference Edit Report

Description of Information

The Provider Locality Cross-Reference Edit Report displays data keyed into the Provider Locality Cross-Reference Control File and error messages for any formatting or relationship errors that may have occurred during input.

Purpose of Report

The Provider Locality Cross-Reference Edit Report provides a means to verify that the data entered in the Provider Locality Cross-Reference Control File is correct in format. When edit messages indicate errors have occurred, the incorrect data should be corrected and resubmitted for editing until no errors are identified.

Sort Sequence

As input

Distribution

Distribution	Media	Copies	Frequency
EDS	Paper	1 copy	On Request

Provider Locality Cross-Reference Edit

Part II Report Definition Information

Functional Area: SURS

Report Number: SRGR021-E

Detailed Field Definitions

Table 7.10 – Field Description

Field	Description
AC LB	Account line of business code. IN indicates Indiana and 9 is for Medicaid.
CD ID	Card, or input, identification code. PLD is valid when TP equal d and PLX is valid when TP equal A, B, or C.
CS	Category of service.
LC XF	Provider locality cross-reference code assigned to the detail code.
TP	Card, or input type.
Locality Description	The provider locality description as keyed on input types B and D.
From	The low code in a range of codes assigned to the cross-reference value.
To	The high code in a range of codes assigned to the cross-reference value.
Edit Message	Message indicates if any error was found and the nature of the error.

Table 7.11 – Footings

Field	Description
Cards Read	The number of inputs acknowledged by the system.
Cards Accepted	The number of inputs that passed all edits.
Cards Rejected	The number of inputs that failed one or more edits.
Total Records Written	The total number of records that were generated as a result of error-free inputs.
Total Masters Displaced	The total number of master records displaced.
Total Warning Messages	The number of warning messages displayed on the edit report.

If no errors were encountered in the report, a message "File Was Created" appears. Otherwise, the message "File Was Not Created" is printed, indicating that the user must correct the errors before the file will be created for cycle generation.

Report Example: Provider Locality Cross-Reference Edit

```
SRGR021 -E                          INDIANA MEDICAID MANAGEMENT INFORMATION SYSTEM                          PAGE 99,999

RUN DATE: MM/DD/CCYY                 PROVIDER LOCALITY CROSS-REFERENCE EDIT REPORT                 PERIOD: MM/CCYY THRU MM/CCYY

----------------------------------CARD IMAGE-----------------------------------

AC CD C LC     T LOCALITY DESCRIPTION/                                          ------------------ EDIT MESSAGE ------------------
LB ID S XF     P FROM     TO

IN9PLD  01     D Adams                                                  PL23-DETAIL DESCRIPTION ACCEPTED

IN9PLD  01     D Allen                                                  PL23-DETAIL DESCRIPTION ACCEPTED

IN9PLD  01     D Batholomew                                             PL23-DETAIL DESCRIPTION ACCEPTED

IN9PLD  01     D Benton                                                 PL23-DETAIL DESCRIPTION ACCEPTED

IN9PLD  01     D Blackford                                              PL23-DETAIL DESCRIPTION ACCEPTED

IN9PLD  01     D Boone                                                  PL23-DETAIL DESCRIPTION ACCEPTED

IN9PLX25L99    A          99                                            PL20-DETAIL DEFINITION ACCEPTED

IN9PLX25ALL    C 01                                                     PL15-CATEGORY DEFINITION ACCEPTED

IN9PLX26L99    A          99                                            PL20-DETAIL DEFINITION ACCEPTED

IN9PLX26ALL    C 01                                                     PL15-CATEGORY DEFINITION ACCEPTED

                                    TOTAL CARDS READ        9,999,999

                                    TOTAL CARDS ACCEPTED    9,999,999

                                    TOTAL CARDS REJECTED    9,999,999

                                    TOTAL RECORDS WRITTEN   9,999,999

                                    TOTAL MASTERS DISPLACED 9,999,999

                                    TOTAL WARNING MESSAGES  9,999,999

                                                 CUSTOMER APPROVAL BY _____________________  DATE _________
```

Report Definition: SRGR025-E Recipient Aid Category Cross-Reference Edit

Part I Report Definition Information

Functional Area:	SURS
Report Number:	SRGR025-E
Job Name:	SRGJQ020
Report Title:	Recipient Aid Category Cross-Reference Edit Report

Description of Information

The Recipient Aid Category Cross-Reference Edit Report displays data keyed into the Recipient Aid Category Cross-Reference Control File and error messages for any formatting or relationship errors that may have occurred during input.

Purpose of Report

The Recipient Aid Category Cross-Reference Edit Report provides a means to verify that the data entered in the Recipient Aid Category Cross-Reference Control File is correct in format. When edit messages indicate errors have occurred, the incorrect data should be corrected and resubmitted for editing until no errors are identified.

Sort Sequence

As input

Distribution

Distribution	Media	Copies	Frequency
EDS	Paper	1 copy	On Request

Recipient Aid Category Cross-Reference Edit

Part II Report Definition Information

Functional Area: SURS

Report Number: SRGR025-E

Detailed Field Definitions

Table 7.12 – Field Description

Field	Description
AC LB	Account line of business code. IN indicates Indiana and 9 is valid for Medicaid.
CD ID	Card, or input, identification code. BAX is valid when TP equal A, B, and C, and BAD is valid when TP equal D.
AID XREF	Recipient aid category cross-reference code assigned to the detail code.
TP	Card, or input type.
Aid Category Description	The recipient aid category description as keyed on input types B and D.
From	The low code in a range of codes assigned to the cross-reference value.
To	The high code in a range of codes assigned to the cross-reference value.
FCE LOC	Force locality indicator code.
Edit Message	Message indicates if any error was found and the nature of the error.

Table 7.13 – Footings

Field	Description
Cards Read	The number of inputs acknowledged by the system.
Cards Accepted	The number of inputs that passed all edits.
Cards Rejected	The number of inputs that failed one or more edits.
Total Records Written	The total number of records that were generated as a result of error-free inputs.
Total Masters Displaced	The total number of master records displaced.
Total Warning Messages	The number of warning messages displayed on the edit report.

If no errors were encountered in the report, a message "File Was Created" appears. Otherwise, the message "File Was Not Created" is printed, indicating that the user must correct the errors before the file will be created for cycle generation.

Report Example: Recipient Aid Category Cross-Reference Edit

SRGR025 -E INDIANA MEDICAID MANAGEMENT INFORMATION SYSTEM PAGE 99,999

RUN DATE: MM/DD/CCYY BENEFICIARY AID CATEGORY CROSS-REFERENCE EDIT REPORT PERIOD: MM/CCYY THRU MM/CCYY

----------CARD IMAGE----------

AC CD LB ID	AID XREF	T P	LOCALITY FROM	DESCRIPTION/ TO	FCE LOC	EDIT MESSAGE
IN9BAX	AFDCM	C	1	1		BA20-DETAIL DEFINITION ACCEPTED
IN9BAD	1	D	MEDICAID FOR CHILDREN UNDER 19			BA23-DETAIL DESCRIPTION ACCEPTED
IN9BAX	AFDC	C	1P	1P		BA20-DETAIL DEFINITION ACCEPTED
IN9BAD	1	D	CHILDREN UNDER 19 REFUGEE			BA23-DETAIL DESCRIPTION ACCEPTED
IN9BAX	AFDCM	C	2	2		BA20-DETAIL DEFINITION ACCEPTED
IN9BAD	1	D	MEDICAID FOR CHILDREN UNDER 6-19			BA23-DETAIL DESCRIPTION ACCEPTED
IN9BAX	AFDC	C	2P	2P		BA20-DETAIL DEFINITION ACCEPTED
IN9BAD	1	D	CHILDREN 6-19 REFUGEE			BA23-DETAIL DESCRIPTION ACCEPTED
IN9BAX	CHINS	C	3	3		BA20-DETAIL DEFINITION ACCEPTED
IN9BAD	1	D	MEDICAID FOR WARDS			BA23-DETAIL DESCRIPTION ACCEPTED
IN9BAX	CHINS	C	3P	3P		BA20-DETAIL DEFINITION ACCEPTED
IN9BAD	1	D	WARDS REFUGEE			BA23-DETAIL DESCRIPTION ACCEPTED
IN9BAX	AFDC	C	4	4		BA20-DETAIL DEFINITION ACCEPTED
IN9BAD	1	D	MEDICAID FOR IV-E FOSTER CHILDREN			BA23-DETAIL DESCRIPTION ACCEPTED
IN9BAX	AFDC	C	4P	4P		BA20-DETAIL DEFINITION ACCEPTED

CUSTOMER APPROVAL BY _____ DATE _____

Report Definition: SRGR024-E Recipient Locality Cross-Reference Edit

Part I Report Definition Information

Functional Area:	SURS
Report Number:	SRGR024-E
Job Name:	SRGJQ020
Report Title:	Recipient Locality Cross-Reference Edit Report

Description of Information

The Recipient Locality Cross-Reference Edit Report displays data keyed into the Recipient Locality Cross-Reference Control File and error messages for any formatting or relationship errors that may have occurred during input.

Purpose of Report

The Recipient Locality Cross-Reference Edit Report provides a means to verify that the data entered in the Recipient Locality Cross-Reference Control File is correct in format. When edit messages indicate errors have occurred, the incorrect data should be corrected and resubmitted for editing until no errors are identified.

Sort Sequence

As input

Distribution

Distribution	Media	Copies	Frequency
EDS	Paper	1 copy	On Request

Recipient Locality Cross-Reference Edit

Part II Report Definition Information

Functional Area: SURS

Report Number: SRGR024-E

Detailed Field Definitions

Table 7.14 – Field Description

Field	Description
AC LB	Account line of business code. IN indicates Indiana and 9 is valid for Medicaid.
CD ID	Card, or input, identification code. BLX is valid when TP equal A, B, or C, and BLD is valid when TP equal D.
LC XF	Recipient locality cross-reference code assigned to the detail code.
TP	Card, or input type.
Locality Description	The recipient locality description as keyed on input types B and D.
From	The low code in a range of codes assigned to the cross-reference value.
To	The high code in a range of codes assigned to the cross-reference value.
Edit Message	Message indicates if any error was found and the nature of the error.

Table 7.15 – Footings

Field	Description
Cards Read	The number of inputs acknowledged by the system.
Cards Accepted	The number of inputs that passed all edits.
Cards Rejected	The number of inputs that failed one or more edits.
Total Records Written	The total number of records that were generated as a result of error-free inputs.
Total Masters Displaced	The total number of master records displaced.
Total Warning Messages	The number of warning messages displayed on the edit report.

If no errors were encountered in the report, a message "File Was Created" appears. Otherwise, the message "File Was Not Created" is printed, indicating that the user must correct the errors before the file will be created for cycle generation.

Report Example: Recipient Locality Cross-Reference Edit

```
  SRGR024 -E                          INDIANA MEDICAID MANAGEMENT INFORMATION SYSTEM                          PAGE 99,999

  RUN DATE: MM/DD/CCYY              BENEFICIARY LOCALITY CROSS-REFERENCE EDIT REPORT              PERIOD: MM/CCYY THRU MM/CCYY

  ----------------------------------CARD IMAGE----------------------------------
AC CD C  LC       T LOCALITY DESCRIPTION/                          ------------------ EDIT MESSAGE ------------------
  LB ID S  XF       P FROM     TO

  IN9BLX   LO1      C 01        01                                                BL20-DETAIL DEFINITION ACCEPTED

  IN9BLD   01       D Adams                                                       BL23-DETAIL DESCRIPTION ACCEPTED

  IN9BLX   LO2      C 02        02                                                BL20-DETAIL DEFINITION ACCEPTED

  IN9BLD   02       D Allen                                                       BL23-DETAIL DESCRIPTION ACCEPTED

  IN9BLX   LO3      C 03        03                                                BL20-DETAIL DEFINITION ACCEPTED

  IN9BLD   03       D Batholomew                                                  BL23-DETAIL DESCRIPTION ACCEPTED

  IN9BLX   LO4      C 04        04                                                BL20-DETAIL DEFINITION ACCEPTED

  IN9BLD   04       D Benton                                                      BL23-DETAIL DESCRIPTION ACCEPTED

  IN9BLX   LO5      C 05        05                                                BL20-DETAIL DEFINITION ACCEPTED

  IN9BLD   05       D Blackford                                                   BL23-DETAIL DESCRIPTION ACCEPTED

  IN9BLX   LO6      C 06        06                                                BL20-DETAIL DEFINITION ACCEPTED

  IN9BLD   06       D Boone                                                       BL23-DETAIL DESCRIPTION ACCEPTED
                                      TOTAL CARDS READ        9,999,999

                                      TOTAL CARDS ACCEPTED    9,999,999

                                      TOTAL CARDS REJECTED    9,999,999

                                      TOTAL RECORDS WRITTEN   9,999,999

                                      TOTAL MASTERS DISPLACED 9,999,999

                                      TOTAL WARNING MESSAGES  9,999,999
                                                    CUSTOMER APPROVAL BY _____________________  DATE _________
```

Report Definition: SRGR026-E Diagnosis Cross-Reference Edit

Part I Report Definition Information

Functional Area:	SURS
Report Number:	SRGR026-E
Job Name:	SRGJQ020
Report Title:	Diagnosis Cross-Reference Edit Report

Description of Information

The Diagnosis Cross-Reference Edit Report displays data keyed into the Diagnosis Cross-Reference Control File and error messages for any formatting or relationship errors that may have occurred during input.

Purpose of Report

The Diagnosis Cross-Reference Edit Report provides a means to verify that the data entered in the Diagnosis Cross-Reference Control File is correct in format. When edit messages indicate errors have occurred, the incorrect data should be corrected and resubmitted for editing until no errors are identified.

Sort Sequence

As input

Distribution

Distribution	Media	Copies	Frequency
EDS	Paper	1 copy	On Request

Diagnosis Cross-Reference Edit

Part II Report Definition Information

Functional Area:	SURS
Report Number:	SRGR026-E

Detailed Field Definitions

Table 716 – Field Description

Field	Description
AC LB	Account line of business code. IN indicates Indiana and 9 is valid for Medicaid.
CD ID	Card, or input, identification code. DGX is valid when TP equal A, B, or C, and DGD is valid when TP equal D.
CS	Category of service.
DIAG XREF	Diagnosis cross-reference code assigned to the detail code.
TP	Card, or input type.
Diagnosis Description	The diagnosis description as keyed on input types B and D.
From	The low code in a range of codes assigned to the cross-reference value.
To	The high code in a range of codes assigned to the cross-reference value.
Edit Message	Message indicates if any error was found and the nature of the error.

Table 717 – Footings

Field	Description
Cards Read	The number of inputs acknowledged by the system.
Cards Accepted	The number of inputs that passed all edits.
Cards Rejected	The number of inputs that failed one or more edits.
Total Records Written	The total number of records that were generated as a result of error-free inputs.
Total Masters Displaced	The total number of master records displaced.
Total Warning Messages	The number of warning messages displayed on the edit report.

If no errors were encountered in the report, a message "File Was Created" appears. Otherwise, the message "File Was Not Created" is printed, indicating that the user must correct the errors before the file will be created for cycle generation.

Report Example: Diagnosis Cross-Reference Edit

```
SRGR026 -E                          INDIANA MEDICAID MANAGEMENT INFORMATION SYSTEM                              PAGE 99,999

RUN DATE: MM/DD/CCYY                     DIAGNOSIS CROSS-REFERENCE EDIT REPORT                    PERIOD: MM/CCYY THRU MM/CCYY
----------------------------------CARD IMAGE-----------------------------------

AC CD C  DIAG    T LOCALITY DESCRIPTION/                              ------------------ EDIT MESSAGE ------------------
LB ID S  XREF    P FROM     TO

IN9DGD   00100   D CHOLERA                                               DG23-DETAIL DESCRIPTION ACCEPTED

IN9DGD   04190   D BACTERIAL INFECTION NOS                               DG23-DETAIL DESCRIPTION ACCEPTED

IN9DGD   04200   D HIV W/SPECIFIED CONDITIONS                            DG23-DETAIL DESCRIPTION ACCEPTED

IN9DGD   04490   D HIV NOS                                              DG23-DETAIL DESCRIPTION ACCEPTED

IN9DGD   05200   D CHICKENPOX                                           DG23-DETAIL DESCRIPTION ACCEPTED

SRGR026 -E                          INDIANA MEDICAID MANAGEMENT INFORMATION SYSTEM                              PAGE 99,999

RUN DATE: MM/DD/CCYY                     DIAGNOSIS CROSS-REFERENCE EDIT REPORT                    PERIOD: MM/CCYY THRU MM/CCYY
----------------------------------CARD IMAGE-----------------------------------

AC CD C  DIAG    T LOCALITY DESCRIPTION/                              ------------------ EDIT MESSAGE ------------------
LB ID S  XREF    P FROM     TO

IN9DGX   X1100   B MYCOSES**********************************           DG18-CROSS-REFERENCE DEFINITION ACCEPTED

IN9DGX   X2100   B BENIGN NEOPLASMS**************************         DG18-CROSS-REFERENCE DEFINITION ACCEPTED

IN9DGX   X2790   B IMMUNE DISORDERS**************************         DG18-CROSS-REFERENCE DEFINITION ACCEPTED
                                        TOTAL CARDS READ        9,999,999

                                        TOTAL CARDS ACCEPTED    9,999,999

                                        TOTAL CARDS REJECTED    9,999,999

                                        TOTAL RECORDS WRITTEN   9,999,999

                                        TOTAL MASTERS DISPLACED 9,999,999

                                        TOTAL WARNING MESSAGES  9,999,999

                                                    CUSTOMER APPROVAL BY _____________________  DATE _________
```

Report Definition: SRGR027-E Procedure Cross-Reference Edit

Part I Report Definition Information

Functional Area:	SURS
Report Number:	SRGR027-E
Job Name:	SRGJQ020
Report Title:	Procedure Cross-Reference Edit Report

Description of Information

The Procedure Cross-Reference Edit Report displays data keyed into the Procedure Cross-Reference Control File and error messages for any formatting or relationship errors that may have occurred during input.

Purpose of Report

The Procedure Cross-Reference Edit Report provides a means to verify that the data entered in the Procedure Cross-Reference Control File is correct in format. When edit messages indicate errors have occurred, the incorrect data should be corrected and resubmitted for editing until no errors are identified.

Sort Sequence

As input

Distribution

Distribution	Media	Copies	Frequency
EDS	Paper	1 copy	On Request

Procedure Cross-Reference Edit

Part II Report Definition Information

Functional Area:	SURS
Report Number:	SRGR027-E

Detailed Field Definitions

Table 7.18 – Field Description

Field	Description
AC LB	Account line of business code. IN indicates Indiana and 9 is valid for Medicaid.
CD ID	Card, or input, identification code. TPX is valid when TP equal A, B, or C, and TPD is valid when TP equal D.
CS	Category of service.
PRC XREF	Procedure cross-reference code assigned to the detail code.
TP	Card, or input type.
Procedure Description	The procedure description as keyed on input types B and D.
From	The low code in a range of codes assigned to the cross-reference value.
To	The high code in a range of codes assigned to the cross-reference value.
Edit Message	Message indicates if any error was found and the nature of the error.

Table 7.19 – Footings

Field	Description
Cards Read	The number of inputs acknowledged by the system.
Cards Accepted	The number of inputs that passed all edits.
Cards Rejected	The number of inputs that failed one or more edits.
Total Records Written	The total number of records that were generated as a result of error-free inputs.
Total Masters Displaced	The total number of master records displaced.
Total Warning Messages	The number of warning messages displayed on the edit report.

If no errors were encountered in the report, a message "File Was Created" appears. Otherwise, the message "File Was Not Created" is printed, indicating that the user must correct the errors before the file will be created for cycle generation.

Report Example: Procedure Cross-Reference Edit

```
SRGR027 -E                          INDIANA MEDICAID MANAGEMENT INFORMATION SYSTEM                                PAGE 99,999

  RUN DATE: MM/DD/CCYY                TYPE SERVICE/PROCEDURE CROSS-REFERENCE EDIT REPORT               PERIOD: MM/CCYY THRU MM/CCYY

  ----------------------------------CARD IMAGE-----------------------------------

  AC CD C  TSPRC  T TYPE SERVICE PROCEDURE DESCRIPTION/                          ------------------ EDIT MESSAGE ------------------
  LB ID S  XREF   P FROM     TO

  IN9TPD     00100D ANESTHESIA                                                  TP23-DETAIL DESCRIPTION ACCEPTED

  IN9TPD     04190D TRANSVENOUS UMBRELLA INSERTION                              TP23-DETAIL DESCRIPTION ACCEPTED

  IN9TPD     04200D ANESTHESIA FOR PROC ON PERINEAL                             TP23-DETAIL DESCRIPTION ACCEPTED

  IN9TPD     04490D UNLISTED ANESTHESIA PROCEDURE                               TP23-DETAIL DESCRIPTION ACCEPTED

  IN9TPD     05200D UNLISTED ARTHROSCOPY                                        TP23-DETAIL DESCRIPTION ACCEPTED

  SRGR027 -E                          INDIANA MEDICAID MANAGEMENT INFORMATION SYSTEM                                PAGE 99,999

  RUN DATE: MM/DD/CCYY                    DIAGNOSIS CROSS-REFERENCE EDIT REPORT                    PERIOD: MM/CCYY THRU MM/CCYY
  ----------------------------------CARD IMAGE-----------------------------------
  AC CD C  TSPRC   T TYPE SERVICE PROCEDURE DESCRIPTION/                         ------------------ EDIT MESSAGE ------------------
  LB ID S  XREF    P FROM     TO
  IN9TPX06X1100    C   Q0091                                                    TP20-DETAIL DEFINITION ACCEPTED

  IN9TPX06X2100    C   Q0092                                                    TP20-DETAIL DEFINITION ACCEPTED

  IN9TPX06X2790    C   X3640                                                    TP20-DETAIL DEFINITION ACCEPTED
                                        TOTAL CARDS READ        9,999,999

                                        TOTAL CARDS ACCEPTED    9,999,999

                                        TOTAL CARDS REJECTED    9,999,999

                                        TOTAL RECORDS WRITTEN   9,999,999

                                        TOTAL MASTERS DISPLACED 9,999,999

                                        TOTAL WARNING MESSAGES  9,999,999


                                      CUSTOMER APPROVAL BY _____________________  DATE _________
```

Report Definition: SRGR022 Provider Type Cross-Reference

Part I Report Definition Information

Functional Area:	SURS
Report Number:	SRGR022
Job Name:	SRGJQ020
Report Title:	Provider Type Cross-Reference Report

Description of Information

The Provider Type Cross-Reference Report displays the type cross-reference scheme established for provider peer grouping.

Purpose of Report

The Provider Type Cross-Reference Report provides a reference of the provider type cross-referencing scheme utilized for quarterly reporting. The report may also be used as a tool in the evaluation of the cross-referencing for purposes of maintaining a statistically valid and treatment-relevant system of peer grouping.

Sort Sequence

Category of service, Cross-reference code, Original code

Distribution

Distribution	Media	Copies	Frequency
IFSSA	Paper	1 copy	Quarterly
EDS	Paper	1 copy	Quarterly and On Request

Provider Type Cross-Reference

Part II Report Definition Information

Functional Area: SURS

Report Number: SRGR022

Detailed Field Definitions

Table 7.20 – Field Description

Field	Description
Category of Service	The SURS category of service of the sequence reported.
Default Assignment	The default value assigned by the user for any detail code which was not assigned to a cross-reference code.

Table 7.21 – Cross-Reference Values

Field	Description
Code	The cross-reference value assigned by the user.
Description	The cross-reference code description defined by the user.

Table 7.22 – Original Values

Field	Description
Code	The original value to be cross-referenced to, and reported by, the cross-reference value assigned by the user.
Description	The original code description defined by the user.

Report Example: Provider Type Cross-Reference

SRGR022 INDIANA MEDICAID MANAGEMENT INFORMATION SYSTEM PAGE 99,999

RUN DATE: MM/DD/CCYY PROVIDER TYPE CROSS-REFERENCE REPORT PERIOD: MM/CCYY THRU MM/CCYY

CATEGORY OF SERVICE - 06 - PHYSICIAN

DEFAULT ASSIGNMENT- T99

----CROSS REFERENCE VALUES----		-----ORIGINAL VALUES-----	
CODE	DESCRIPTION	CODE	DESCRIPTION
T08	Clinic	008	Clinic
T08	Advance Practice Nurse	009	Advance Practice Nurse
T08	Mid Level Practitioner	010	Mid Level Practitioner
T08	Physician	031	Physician

CUSTOMER APPROVAL BY _____ DATE _____

Report Definition: SRGR023 Provider Specialty Cross-Reference

Part I Report Definition Information

Functional Area:	SURS
Report Number:	SRGR023
Job Name:	SRGJQ020
Report Title:	Provider Specialty Cross-Reference Report

Description of Information

The Provider Specialty Cross-Reference Report displays the specialty cross-reference scheme established for provider peer grouping.

Purpose of Report

The Provider Specialty Cross-Reference Report provides a reference of the provider specialty cross-referencing scheme utilized for quarterly reporting. The report may also be used as a tool in the evaluation of the cross-referencing for purposes of maintaining a statistically valid and treatment-relevant system of peer grouping.

Sort Sequence

Category of service, Cross-reference code, Original code

Distribution

Distribution	Media	Copies	Frequency
IFSSA	Paper	1 copy	Quarterly
EDS	Paper	1 copy	Quarterly and On Request

Provider Specialty Cross-Reference

Part II Report Definition Information

Functional Area: SURS

Report Number: SRGR023

Detailed Field Definitions

Table 7.23 – Field Description

Field	Description
Category of Service	The SURS category of service of the sequence reported.
Default Assignment	The default value assigned by the user for any detail code that was not assigned to a cross-reference code.
Default Force Locality	The default locality value assigned by the user on the Provider Locality cross-reference file.

Table 7.24 – Cross-Reference Values

Field	Description
Code	The cross-reference value assigned by the user.
Description	The cross-reference code description defined by the user.

Table 7.25 – Original Values

Field	Description
Code	The original value to be cross-referenced to, and reported by, the cross-reference value assigned by the user.
Description	The original code description defined by the user.
Force	The force locality to be used for peer grouping the associated cross-reference specialty code.

Report Example: Provider Specialty Cross-Reference

SRGR023 INDIANA MEDICAID MANAGEMENT INFORMATION SYSTEM PAGE 99,999

RUN DATE: MM/DD/CCYY PROVIDER SPECIALTY CROSS REFERENCE REPORT PERIOD: MM/CCYY THRU MM/CCYY

CATEGORY OF SERVICE - 01 - INPATIENT

DEFAULT ASSIGNMENT- S99

DEFAULT FORCE LOCALITY - UNUSED

----CROSS REFERENCE VALUES----		-----ORIGINAL VALUES-----		
CODE	DESCRIPTION	CODE	DESCRIPTION	FORCE
S010	ACUTE CARE HOSPITAL	010	ACUTE CARE HOSPITAL	
S011	PSYCHIATRIC HOSPITAL	011	PSYCHIATRIC HOSPITAL	
S012	REHABILITATION HOSPITAL	012	REHABILITATION HOSPITAL	

CUSTOMER APPROVAL BY _____ DATE _____

Report Definition: SRGR021 Provider Locality Cross-Reference

Part I Report Definition Information

Functional Area:	SURS
Report Number:	SRGR021
Job Name:	SRGJQ020
Report Title:	Provider Locality Cross-Reference Report

Description of Information

The Provider Locality Cross-Reference Report displays the locality cross-reference scheme established for provider peer grouping.

Purpose of Report

The Provider Locality Cross-Reference Report provides a reference of the provider locality cross-referencing scheme utilized for quarterly reporting. The report may also be used as a tool in the evaluation of the cross-referencing for purposes of maintaining a statistically valid and treatment-relevant system of peer grouping.

Sort Sequence

Category of service, Cross-reference code, Original code

Distribution

Distribution	Media	Copies	Frequency
IFSSA	Paper	1 copy	Quarterly
EDS	Paper	1 copy	Quarterly and On Request

Provider Locality Cross-Reference

Part II Report Definition Information

Functional Area: SURS

Report Number: SRGR021

Detailed Field Definitions

Table 7.26 – Field Description

Field	Description
Category of Service	The SURS category of service of the sequence reported.
Default Assignment	The default value assigned by the user for any detail code which was not assigned to a cross-reference code.
Locality Source	The locality source selected by the user on the Account Cycle Control Data and Customer Options File to be used for provider peer grouping.

Table 7.27 – Cross-Reference Values:

Field	Description
Code	The cross-reference value assigned by the user.
Description	The cross-reference code description defined by the user.

Table 7.28 – Original Values:

Field	Description
Code	The original value to be cross-referenced to, and reported by, the cross-reference value assigned by the user.
Description	The original code description defined by the user.

Report Example: Provider Locality Cross-Reference

```
SRGR021                          INDIANA MEDICAID MANAGEMENT INFORMATION SYSTEM                          PAGE 99,999
RUN DATE: MM/DD/CCYY                PROVIDER LOCALITY CROSS-REFERENCE REPORT          PERIOD: MM/CCYY THRU MM/CCYY
                                          CATEGORY OF SERVICE - 01  - INPATIENT
                                       DEFAULT ASSIGNMENT-  L99
                                       LOCALITY SOURCE - CNTY

 ----CROSS REFERENCE VALUES----          -----ORIGINAL VALUES-----
 CODE        DESCRIPTION                 CODE          DESCRIPTION
ALL     ALL                             01      Adams
                                        02      Allen
                                        03      Batholomew
                                        04      Blackford
                                        05      Benton
                                        06      Brown
                                      CUSTOMER APPROVAL BY _____________________ DATE _________
```

Report Definition: SRGR025 Recipient Aid Category Cross-Reference

Part I Report Definition Information

Functional Area:	SURS
Report Number:	SRGR025
Job Name:	SRGJQ020
Report Title:	Recipient Aid Category Cross-Reference Report

Description of Information

The Recipient Aid Category Cross-Reference Report displays the recipient aid category cross-reference scheme established for recipient peer grouping.

Purpose of Report

The Recipient Aid Category Cross-Reference Report provides a reference of the recipient aid category cross-referencing scheme utilized for quarterly reporting. The report may also be used as a tool in the evaluation of the cross-referencing for purposes of maintaining a statistically valid and treatment-relevant system of peer grouping.

Sort Sequence

Cross-reference code, Original code

Distribution

Distribution	Media	Copies	Frequency
IFSSA	Paper	1 copy	Quarterly
EDS	Paper	1 copy	Quarterly and On Request

Recipient Aid Category Cross-Reference

Part II Report Definition Information

Functional Area: SURS

Report Number: SRGR025

Detailed Field Definitions

Table 7.29 – Field Description

Field	Description
Default Assignment	The default value assigned by the user for any detail code which was not assigned to a cross-reference code.
Default Force Locality	The default locality value assigned by the user on the Beneficiary Locality cross-reference file.

Table 7.30 – Cross-Reference Values:

Field	Description
Code	The cross-reference value assigned by the user.
Description	The cross-reference code description defined by the user.

Table 7.31 – Original Values:

Field	Description
Code	The original value to be cross-referenced to, and reported by, the cross-reference value assigned by the user.
Description	The original code description defined by the user.
Force	The force locality to be used for peer grouping the associated cross-reference aid category code.

Report Example: Recipient Aid Category Cross-Reference

```
SRGR025                              INDIANA MEDICAID MANAGEMENT INFORMATION SYSTEM                              PAGE 99,999
RUN DATE: MM/DD/CCYY                  BENEFICIARY AID CATEGORY CROSS-REFERENCE REPORT          PERIOD: MM/CCYY THRU MM/CCYY
                                              DEFAULT ASSIGNMENT-  XXAID
                                             DEFAULT FORCE LOCALITY - UNUSED

                  ----CROSS REFERENCE VALUES----            -----------ORIGINAL VALUES-----
                   CODE        DESCRIPTION                   CODE          DESCRIPTION         FORCE
                  AFDC    AFDC RELATED RECIPIENTS           1P      CHILDREN UNDER 19 REFUGE
                                                            2P      CHILDREN 6-19 REFUGE
                                                            4       MEDICAID FOR IV-E FOSTER
                                                            4P      MEDICAID FOR FOSTER CHIL
                                                            8       MEDICAID FOR IV-E ADOPTI
                                                            8P      MEDICAID FOR ADOPTION
                                                            CP      AFDC RELATED REFUGE
                                                          CUSTOMER APPROVAL BY _____________________ DATE _________
```

Report Definition: SRGR024 Recipient Locality Cross-Reference

Part I Report Definition Information

Functional Area:	SURS
Report Number:	SRGR024
Job Name:	SRGJQ020
Report Title:	Recipient Locality Cross-Reference Report

Description of Information

The Recipient Locality Cross-Reference Report displays the recipient locality cross-reference scheme established for recipient peer grouping.

Purpose of Report

The Recipient Locality Cross-Reference Report provides a reference of the recipient locality cross-referencing scheme utilized for quarterly reporting. The report may also be used as a tool in the evaluation of the cross-referencing for purposes of maintaining a statistically valid and treatment-relevant system of peer grouping.

Sort Sequence

Cross-reference code, Original code

Distribution

Distribution	Media	Copies	Frequency
IFSSA	Paper	1 copy	Quarterly
EDS	Paper	1 copy	Quarterly and On Request

Recipient Locality Cross-Reference

Part II Report Definition Information

Functional Area: SURS

Report Number: SRGR024

Detailed Field Definitions

Table 7.32 – Field Description

Field	Description
Locality Source	The locality source selected by the user on the Account Cycle Control Data and Customer Options File to be used for recipient peer grouping.
Default Assignment	The default value assigned by the user for any detail code which was not assigned to a cross-reference code.

Table 7.33 – Cross-Reference Values

Field	Description
Code	The cross-reference value assigned by the user.
Description	The cross-reference code description defined by the user.

Table 7.34 – Original Values

Field	Description
Code	The original value to be cross-referenced to, and reported by, the cross-reference value assigned by the user.
Description	The original code description defined by the user.

Report Example: Recipient Locality Cross-Reference

SRGR024 INDIANA MEDICAID MANAGEMENT INFORMATION SYSTEM PAGE 99,999

RUN DATE: MM/DD/CCYY BENEFICIARY LOCALITY CROSS-REFERENCE REPORT PERIOD: MM/CCYY THRU MM/CCYY

LOCALITY SOURCE - CNTY

DEFAULT ASSIGNMENT- L99

----CROSS REFERENCE VALUES----		-----ORIGINAL VALUES-----	
CODE	DESCRIPTION	CODE	DESCRIPTION
L12	Adams	12	Adams
L13	Allen	13	Allen
L14	Batholomew	14	Batholomew
L15	Blackford	15	Blackford
L16	Benton	16	Benton
L17	Brown	17	Brown

CUSTOMER APPROVAL BY _____ DATE _____

Report Definition: SRGR026 Diagnosis Cross-Reference

Part I Report Definition Information

Functional Area: SURS

Report Number: SRGR026

Job Name: SRGJQ020

Report Title: Diagnosis Cross-Reference Report

Description of Information

The Diagnosis Cross-Reference Report displays the diagnosis code cross-reference scheme established for treatment analysis processing.

Purpose of Report

The Diagnosis Cross-Reference Report provides a reference of the diagnosis code cross-referencing scheme utilized for treatment analysis processing and reporting. The report may also be used as a tool in the evaluation of the cross-referencing for purposes of maintaining a statistically valid and treatment-relevant system of peer grouping.

Sort Sequence

Category of Service, Cross-reference code, Original code

Distribution

Distribution	Media	Copies	Frequency
IFSSA	Paper	1 copy	Quarterly
EDS	Paper	1 copy	Quarterly and On Request

Diagnosis Cross-Reference

Part II Report Definition Information

Functional Area: SURS

Report Number: SRGR026

Detailed Field Definitions

7.35 – Field Description

Field	Description
Category of Service	The SURS category of service of the cross-referencing scheme reported.
Default Assignment	The default value assigned by the user for any detail code that was not assigned to a cross-reference code.

Table 7.36 – Cross-Reference Values

Field	Description
Code	The cross-reference value assigned by the user.
Description	The cross-reference code description defined by the user.

Table 7.37 – Original Values

Field	Description
From	The original from value in the range of codes to be cross-referenced to, and reported by, the cross-reference value assigned by the user.
To	The original to value in the range of codes to be cross-referenced to, and reported by, the cross-reference value assigned by the user.
Description	The original code description defined by the user.

Report Example: Diagnosis Cross-Reference

```
SRGR026                                INDIANA MEDICAID MANAGEMENT INFORMATION SYSTEM                                PAGE 99,999

RUN DATE: MM/DD/CCYY                          DIAGNOSIS CROSS-REFERENCE REPORT                      PERIOD: MM/CCYY THRU MM/CCYY

                                                   CATEGORY OF SERVICE - 06  - PHYSICIAN

                                                 DEFAULT ASSIGNMENT-  X9999

--------------------CROSS REFERENCE VALUES-----------------------   ---------------------------ORIGINAL VALUES----------------------

CODE                    DESCRIPTION                                 FROM/TO                            DESCRIPTION

                                                                     38200    ACUTE SUPP OTITIS MEDIA NOS
                                                                     38290    OTITIS MEDIA NOS

X4010     HYPERTENSIONS*****************************************    40110    BENIGN HYPERTENSION
                                                                     40190

                                                                     40210    HYPERTENSION HEART DIS NOS
                                                                     40291    HYPERTENSION HEART DISEASE

X4100     ISCHEMIC HEART DISEASE-ACUTE**************************    40000    AMI ANTEROLATERAL WAA
                                                                     41090    MYOCARDIAL INFARCTION NOS


                                                        CUSTOMER APPROVAL BY _____________________________ DATE _________
```

Report Definition: SRGR027 Procedure Cross-Reference

Part I Report Definition Information

Functional Area:	SURS
Report Number:	SRGR027
Job Name:	SRGJQ020
Report Title:	Procedure Cross-Reference Report

Description of Information

The Procedure Cross-Reference Report displays the procedure code cross-reference scheme established for treatment analysis processing.

Purpose of Report

The Procedure Cross-Reference Report provides a reference of the procedure code cross-referencing scheme utilized for treatment analysis processing and reporting. The report may also be used as a tool in the evaluation of the cross-referencing for purposes of maintaining a statistically valid and treatment-relevant system of peer grouping.

Sort Sequence

Category of Service, Cross-reference code, Original code

Distribution

Distribution	Media	Copies	Frequency
IFSSA	Paper	1 copy	Quarterly
EDS	Paper	1 copy	Quarterly and On Request

Procedure Cross-Reference

Part II Report Definition Information

Functional Area: SURS

Report Number: SRGR027

Detailed Field Definitions

Table 7.38 – Field Description

Field	Description
Category of Service	The SURS category of service of the cross-referencing scheme reported.
Default Assignment	The default value assigned by the user for any detail code that was not assigned to a cross-reference code.

Table 7.39 – Cross-Reference Values:

Field	Description
Code	The cross-reference value assigned by the user.
Description	The cross-reference code description defined by the user.

Table 7.40 – Original Values:

Field	Description
From	The original from value in the range of codes to be cross-referenced to, and reported by, the cross-reference value assigned by the user.
To	The original to value in the range of codes to be cross-referenced to, and reported by, the cross-reference value assigned by the user.
Description	The original code description defined by the user.

Report Example: Procedure Cross-Reference

```
SRGR027                              INDIANA MEDICAID MANAGEMENT INFORMATION SYSTEM                              PAGE 99,999

RUN DATE: MM/DD/CCYY                   TYPE SERVICE/PROCEDURE CROSS-REFERENCE REPORT            PERIOD: MM/CCYY THRU MM/CCYY

                                                CATEGORY OF SERVICE - 06  - PHYSICIAN

                                              DEFAULT ASSIGNMENT-  X9999

--------------------CROSS REFERENCE VALUES-----------------------   ---------------------------ORIGINAL VALUES----------------------

CODE                    DESCRIPTION                                 FROM/TO                          DESCRIPTION

                                                                      -86999  UNLISTED IMMUNOLOGY PROCEDURE

X5-008     LAB - MICROBIOLOGY**************************************   -87001  ANIMAL INOCULATION, SMALL ANIMAL WITH OBSERVATION
                                                                      -87999  UNLISTED MICOBIOLOGY PROCEDURE

X5-009     LAB – ANATOMIC PATHOLOGY********************************   -88104  CYTOPATH FID EXCEPT
                                                                      -88199  UNLISTED CYTOPATH PROCEDURE

                                                                      -P3000  SCREENING PAP SMEAR BY TECH
                                                                      -P3001  SCREENING PAP SMEAR BY PHYSICIAN

                                                                      -Q0091  SCREENING PAP SMEAR
                                                                      -Q0091  SCREENING PAP SMEAR


X5-010     LAB – SURGICAL PATHOLOGY********************************   -88300  SURGICAL PATHOLOGY, GROSS EXAMINATION ONLY
                                                                      -88399  UNLISTED SURGICAL PATHOLOGY PROCEDURE


                                                                        CUSTOMER APPROVAL BY _____________________ DATE _________
```

Selected Provider and Recipient Control

Selected providers and/or beneficiaries for whom the user requires hard copy reports are identified prior to the quarterly cycle and a selection control file is built.

Summary profiles will be produced for the specified beneficiaries. For providers, the user has the option to produce:

- Summary Profile
- Treatment Exception
- Selected Provider Detail History / Random Sample

Only the needed reports will be produced. Different date ranges for each selected provider's history details, procedure code and detail, random sample reports can be specified and can include from one month up to the 36 months retained on the master file. With this option, only the amount of history needed on each provider will be generated. The three provider history reports can be produced on an as needed basis.

Maintenance of Selected Provider and Recipient Control

The user is responsible for maintaining the control file used to create the selected provider/beneficiary file. Edit reports will be produced indicating any errors.

The selected provider control file is input through on-line screens. As the files are built, some on-line editing is performed to detect format or coding errors. Once all inputs have been entered, another edit process is performed. If no errors are detected, the selected provider/beneficiary control file is built and a report listing the selected providers/beneficiaries with their options is produced. If errors are detected, edit reports will be produced which will identify the errors for correction.

Examples of the windows used for selected provider and recipient criteria input, and the resulting Selected Provider/Beneficiary Edit Reports generated follow with corresponding field descriptions of each window definition: Provider Summary / TA Select

Introduction

The Surveillance and Utilization Review Provider Summary/TA Select Window is used to specify providers for whom a summary profile or treatment analysis profile will automatically be generated.

The SUR Provider Summary/TA Select Window will be accessed utilizing the mouse by clicking the Selected Providers (30 File) button on the SUR Main Menu or by pressing ALT + 3 on the keyboard.

Field Information

Table 7.41 – Field Description

Field	Description
FIELD NAME:	PROVIDER NUMBER
DESCRIPTION:	The Medicaid identification number of the provider
FORMAT:	9 digit, numeric
FEATURES:	None
EDITS:	91019 - Record already exists
TO CORRECT:	Verify keying. The provider number keyed is a duplicate.
	91038 - Provider number must be 9 characters!
TO CORRECT:	Verify keying and enter valid 9 digit, numeric provider number.
	4146 - Invalid provider number.
TO CORRECT:	Verify keying. The provider number keyed is not enrolled in the Medical Assistance Programs.
FIELD NAME:	SUM SEL
DESCRIPTION:	An "X" in this field indicates that a Selected Provider Summary Profile Report is requested for the provider
FORMAT:	X
FEATURES:	System plug X when field is clicked with mouse
EDITS:	80007 - Either Summary or Treatment must be selected.
TO CORRECT:	This error occurs when the save button is clicked before selecting either sum sel or treatment sel. Select summary or treatment by clicking on the Sum Sel and/or Treat Sel fields for the provider.
FIELD NAME:	TREAT SEL
DESCRIPTION:	An "X" in this field indicates if a Provider Treatment Exception Report is requested for the provider
FORMAT:	X
FEATURES:	System plug X when field is clicked with mouse
EDITS:	80007 - Either Summary or Treatment must be selected.
TO CORRECT:	This error occurs when the save button is clicked before selecting either sum sel or treatment sel. Select summary or treatment by clicking on the Sum Sel and/or Treat Sel fields for the provider.
FIELD NAME:	TOTAL PROVIDER RECORDS
DESCRIPTION:	The total number of records that are displayed.
FORMAT:	4 digit, numeric
FEATURES:	System generated
EDITS:	None
TO CORRECT:	N/A

Table 7.42 – Other messages / edits

Message	Edit
"Save successful"	Save button
"Save unsuccessful"	Save button
"Do you really want to delete this record?"	Delete button
"Delete successful"	Delete button
"Delete unsuccessful"	Delete button
"Continue without saving?"	Exit button

Window Example: Provider Summary / TA Select

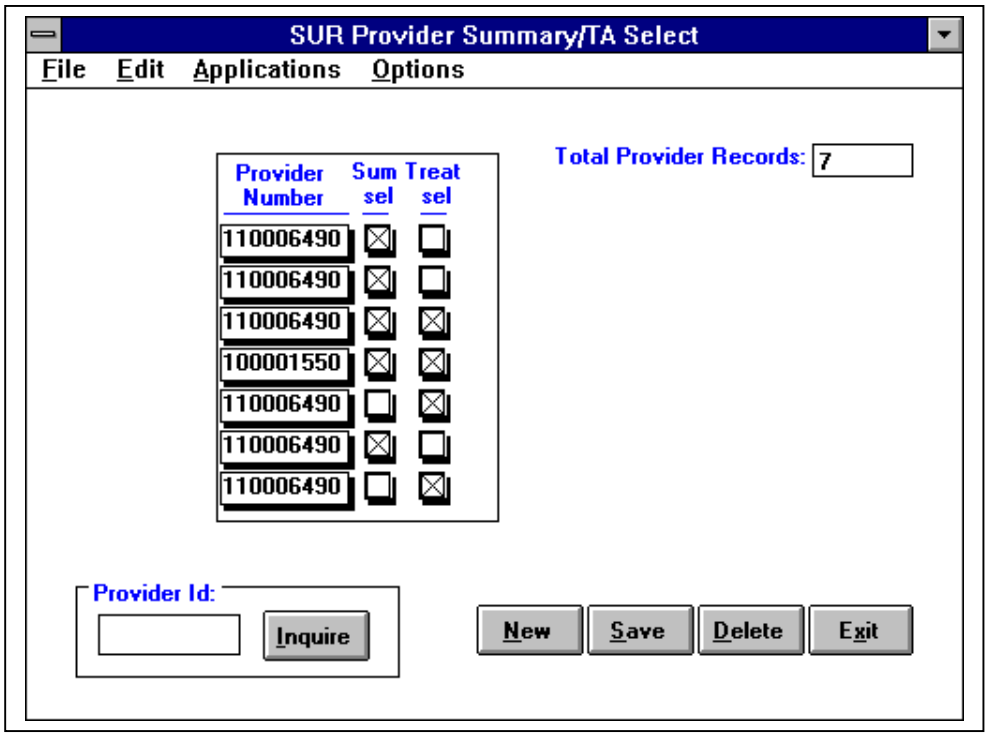

Figure 8

Window Definition: SUR Recipient Summary Select

Introduction

The Surveillance and Utilization Review (SUR) Recipient Summary Select Window is used to identify the recipients for whom a selected summary profile will be automatically produced.

The SUR Recipient Summary Select Window will be accessed utilizing the mouse by clicking the Selected Recipient (60 File) button on the SUR Main Menu or by pressing ALT + 6 on the keyboard.

Field Information

Table 7.43 Field Description

Field	Description
FIELD NAME:	RECIPIENT NUMBER
DESCRIPTION:	The recipient's Medicaid identification number. Entry of a recipient number in the Recipient Number field indicates that a Selected Recipient Summary Profile Report is requested for the recipient.
FORMAT:	12 digit, numeric
FEATURES:	None
EDITS:	91019 - Recipient already exists!
TO CORRECT:	The recipient number keyed is a duplicate. Verify the correct recipient number was keyed. If the correct number was keyed delete the duplicate.
	80029 - Recipient number must be 12 characters!
TO CORRECT:	Verify keying and enter valid 12 digit, numeric recipient number.
	80032 - Invalid Recipient
TO CORRECT:	Verify keying and enter valid 12 digit, numeric recipient number.
FIELD NAME:	TOTAL RECIPIENT RECORDS
DESCRIPTION:	The total number of records that are carried on the file
FORMAT:	4 digit, numeric
FEATURES:	System generated
EDITS:	None
TO CORRECT:	N/A

Table 7.44 – Other messages / edits

Message	Edit
"Save successful"	Save button
"Save unsuccessful"	Save button
"Do you really want to delete this record?"	Delete button
"Delete successful"	Delete button
"Delete unsuccessful"	Delete button
"Continue without saving?"	Exit button

Window Example: SUR Recipient Summary Select

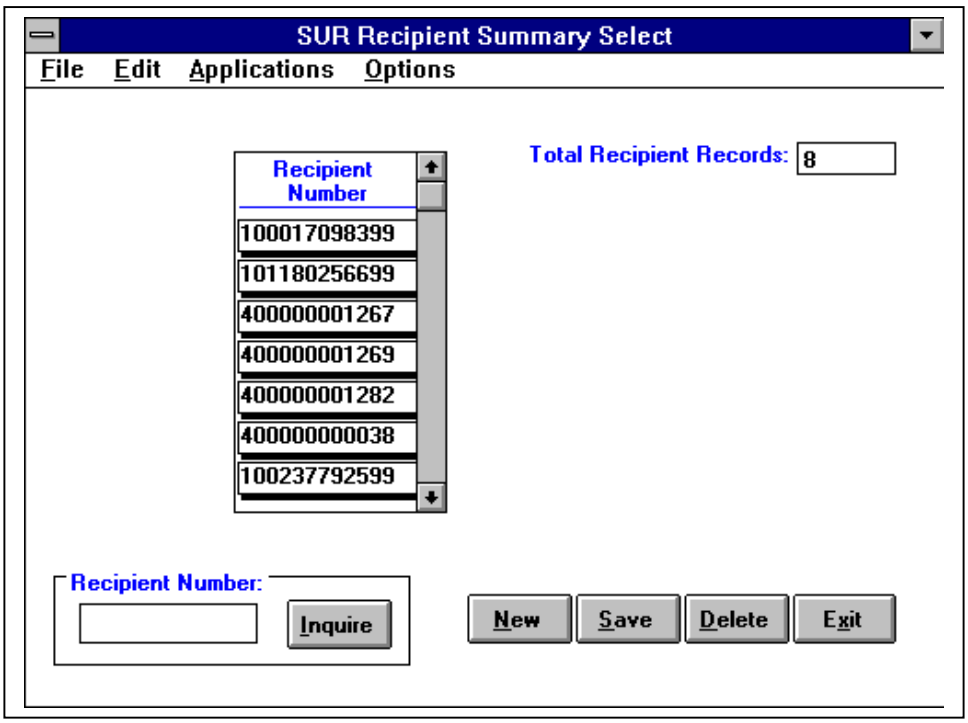

Figure 9 – SUR recipient Summary Select Window

Summary Profile Line Item Control

Line items which appear on the Summary Profiles must be defined for each provider category of service and report sequence, and for the beneficiary subsystem. The line items selected should be supportive of the current SUR strategy of the State. Line items and their exception limits can be changed quarterly if necessary.

Within RAMS II, the capability exists to design up to nine different sets of line items (report sequences) for each provider category of service and for the Recipient Subsystem. One hundred lines items are available for each report sequence; although a carefully designed set of report lines will accomplish the goal of identifying areas of suspected abuse and over utilization using far less than 100 lines. The volume of data to be produced, and subsequently analyzed, should be taken into consideration.

Provider Subsystem

Up to five specialty cross-reference codes can be assigned to a report sequence (set of line items) within a category of service. This will allow the user to tailor the exception parameters to the expected medical activity of the different specialties.

Beneficiary Subsystem

Up to five beneficiary aid cross-reference codes can be assigned to each set of line items.

Exception limits can be applied to the line items as either fixed values or a percentage difference above or below the peer group average.

The following guidelines and form are used for thorough and consistent documentation, and will provide a comprehensive historical record of changes to the SUR data base.

1. Examine the factors involved with the proposed line item, or which may have caused the discrepancy/need for change to the already established line item. Some factors may include; Indiana Code, medical policy, abusive area suspected, low/high exception percentage.

2. Get supporting evidence or examples of problem cases.

3. Discuss any questions or problems with the individual who knows about it. DO NOT RELY ON SECOND HAND INFORMATION.

4. Thoroughly document the proposed change/addition through the use of memos, written policies, reports, statistics, etc.. Attach these to your request.

5. Talk with the person responsible for the data base changes. Be sure to state the request/problem and show specific examples.

6. Once the change/addition is approved and implemented, it is the responsibility of the requester to analyze the results utilizing data from the most recent quarter.

7. Determine whether the results are satisfactory or if further modification is required.

DATA ELEMENT CHANGE REQUEST

DATE:
ORIGINATOR:
COS: CLASS GROUP(S):
LINE #: LINE TITLE:
EXCEPTION PARAMETER APPLIED?:

ADD **CHANGE** **DELETE**

REASON FOR CHANGE:

SUPPORTING DOCUMENTATION

DEFINITION

_IMPLEMENTATION SCHEDULED FOLLOW-UP EVAL

Once the user has determined the line items desired, it must be decided how the information is to be extracted and how to use the accumulated data on the report line. The following factors are involved in the definition of a line item. A list of the specific codes is provided later in this section.

Extract Code

Identifies the type of information to be extracted, such as procedure codes, place of service codes, patient age, and so forth.

Major/Minor Category Code

The minor code is a two digit code assigned to the extract code definition and is used when coding the line item equation. A major code captures the data for all minor codes in its group, i.e. 20 is the major code for minor codes 21-29. There are 15 major codes available (10 - 90, and A0 - F0) with 9 minor codes each, resulting in 150 available category codes to be defined by the user. The major and minor codes are as follows:

Table 7.45 – Category Codes

Major	Minor
10	11-19
20	21-29
30	31-39
40	41-49
50	51-59
60	61-69
70	71-79
80	81-89
90	91-99
A0	A1-A9
B0	B1-B9
C0	C1-C9
D0	D1-D9
E0	E1-E9
F0	F1-F9

Standard Code

Used to obtain information commonly required by most users for which the extract definition is always the same. Standard codes are represented by two alpha characters. Standard codes are as follow:

Table 7.46 – Standard Codes

Code	Description
MD	Medicaid
MR	Medicare
MM	Medicaid and Medicare
DG	Diagnosis Xref Codes
SD	Same Day Same Drug
DR	Drug Refills
PF	Professional Fees
RP	Drug Referring Physician
PH	Pharmacy Count
PA	Prior Authorized
RA	Readmissions

Accumulation Code

A numeric code appended to the two-digit extract code which indicates what information is to be accumulated, i.e. number of services, number of recipients, amount billed, etc. These accumulation codes are commonly referred to as "buckets".

Operands

A combination of a category code (major/minor or standard) and an accumulation code.

Formula Code

A two-digit numeric code that defines the mathematical operation to be performed on the operands for the line item. For example, formula code 01 means add operand A to operand B.

Line Equation

Combination of the formula code and the operands to be used in calculating the data for a line. Up to five operands can be used in each equation.

Line Description

The actual text that will appear on the summary profile to identify the type of information being reported.

Exception Limits

The user supplied values which represent the maximum and/or minimum acceptable values for the line. Four types of limits are available:

- Low percent variance
- Low fixed value
- High percent variance
- High fixed value

Only one high and one low limit can be used on a given line. The percent variances are measured against the peer group average for the reference period.

Report Sequencee

An alpha character which identifies the different report formats when more than one set of line items is used within a category of service. Up to five specialty groups/aid category groups can be assigned to a report sequence.

On the following pages are tables of the extract codes and their formats, the standard codes, accumulation codes, and formula codes for reference in defining and maintaining report line items.

Table 7.47 – Accumulation Codes

Code	Description
1	Number of services
2	Amount billed
3	Amount allowed
4	Amount paid
5	Number of claims
6	Bene / Provider count
7	Prescribed units / quantity
8	Days span / supply
9	Occurrences

Table 7.48 – Formula Codes

Code	Formula	Code	Formula	Code	Formula
00	ONE OPERAND	24	(A%B)*C	48	(A-B)%(C+D)
01	A+B	25	(A*B)%C	49	A+B+C+D+E
02	A-B	26	A+B+C+D	50	A+B+C+D-E
03	A*B	27	A+B+C-D	51	A+B+C-D-E
04	A/B	28	(A+B)/(C+D)	52	A+B-C-D-E
05	A%B	29	(A+B)%(C+D)	53	(A+B+C)/(D+E)
06	A+B+C	30	(A+B)/(C-D)	54	(A+B+C)%(D+E)
07	A+B-C	31	(A-B)/(C-D)	55	(A+B-C)/(D+E)
08	A+(B*C)	32	(A-B)%(C-D)	56	(A+B-C)%(D+E)
09	A+(B/C)	33	(A+B+C)/D	57	(A+B+C)/(D-E)
10	A-B+C	34	(A+B+C)%D	58	(A+B+C)%(D-E)
11	A-B-C	35	(A+B-C)/D	59	(A-B-C)/(D+E)
12	A-(B*C)	36	(A+B-C)%D	60	(A-B-C)%(D+E)
13	A-(B/C)	37	A/(B+C+D)	61	(A-B)/(C+D+E)
14	(A+B)/C	38	A%(B+C+D)	62	(A-B)%(C+D+E)
15	(A+B)%C	39	A+B-C-D	63	(A+B)/(C+D-E)
16	(A-B)/C	40	A-B-C-D	64	(A+B)%(C+D-E)
17	(A-B)%C	41	(A-B-C)/D	65	(A-B)/(C+D-E)
18	A/(B+C)	42	(A-B-C)%D	66	(A-B)%(C+D-E)
19	A/(B-C)	43	A/(B+C-D)	67	(A+B)/(C-D-E)
20	A%(B+C)	44	A%(B+C-D)	68	(A+B)%(C-D-E)
21	A%(B-C)	45	A/(B-C-D)	69	A-B-C-D-E
22	(A*B)/C	46	A%(B-C-D)	70	(A-B)/(C-D-E)
23	(A/B)*C	47	(A-B)/(C+D)	71	(A-B)%(C-D-E)

\+ ADDITION * MULTIPLICATION / DIVISION
\- SUBTRACTION % COMPUTE PERCENTAGE

Table 7.49 – Line Item Description

DATA TYPE	DATA TYPE CODE	CODE FORMAT
Admission for day of week	ADM-DOW	DDD
Admission for procedure	ADM-TSP	XBBBBBBBBBB
Admitting diagnosis	ADGN	AAXAAA
Admitting diagnosis for procedure	ADGN-TSP	AAXAAA-XBBBBBBBBBB
Calculated percentage value of DRG mean length of stay to be equal to or less than for each DRG	DRG-MLOS	9999 (plus control file entry)
Claim type	CLM	X
Claim type for diagnosis	CLM-DGN	X-AAXAAA
Claim type for diagnosis and procedure	CLM-DGN-TSP	X-AAXAAA-XBBBBBBBBBB
Claim type for place of service and procedure	CLM-POS-TSP	X-99-XBBBBBBBBBB

Table 7.49 – Line Item Description

DATA TYPE	DATA TYPE CODE	CODE FORMAT
Claim type for procedure	CLM-TSP	X-XBBBBBBBBBB
Day of week for procedure	DOW-TSP	DDD-XBBBBBBBBBB
Day surgeries	IP5	(*)n/a
Days stay	IP6	(*)n/a
Diagnosis and secondary diagnosis	DGN-SDGN	AAXAAA-AAXAAA
Diagnosis and secondary diagnosis for procedure	DGN-SDGN-TSP	AAXAAA-AAXAAA- XBBBBBBBBBB
Diagnosis code	DGN	AAXAAA
Diagnosis for discharge status code and day of week	DGN-DSC-DOW	AAXAAA-DDD
Diagnosis for modifier and procedure	DGN-MOD-TSP	AAXAAA-XX-XBBBBBBBBBB
Diagnosis for place of service and modifier and procedure	DGN-POS-MOD-TSP	AAXAAA-99-XX-XBBBBBBBBBB
Diagnosis for place of service and procedure	DGN-POS-TSP	AAXAAA-99-XBBBBBBBBBB
Diagnosis for procedure	DGN-TSP	AAXAAA-XBBBBBBBBBB
Diagnosis related grouping	DRG	9999
Discharge diagnosis	DSC-DGN	99-AAXAAA
Discharge for day of week	DSC-DOW	DDD
Discharge status code	DSC	99
Discharge status code for procedure	DSC-TSP	99-XBBBBBBBBBB
Drug referring physician	RP	(*)n/a
Drug refill	DR	(*)n/a
Drug refill for procedure	DR-TSP	XBBBBBBBBBB
Explanation of benefit code	SCC	999
Explanation of benefit code for procedure	SCC-TSP	999-XBBBBBBBBBB
Grouper diagnosis code	GRP-DGN	AAXAAA
Grouper procedure code	GRP-PRO	XBBBBBBBBBB
Hospital leave days	HLD (**)	999
Length of stay	LOS	999
Length of stay for diagnosis	LOS-DGN	999-AAXAAA
Length of stay for procedure	LOS-TSP	999-XBBBBBBBBBB
Medicaid	MD	(*)n/a
Medicaid and Medicare	MM	(*)n/a
Medicare	MR	(*)n/a
Modifier for procedure	MOD-TSP	XX-XBBBBBBBBBB

Table 7.49 – Line Item Description

DATA TYPE	DATA TYPE CODE	CODE FORMAT
Place of service	POS	99
Place of service for diagnosis	POS-DGN	99-AAXAAA
Place of service for diagnosis and procedure	POS-DGN-TSP	99-AAXAAA-XBBBBBBBBBB
Place of service for procedure	POS-TSP	99-XBBBBBBBBBB
Post-op days	IP4	(*)n/a
Pre-op days	IP3	(*)n/a
Post-op days for attending physician	ATT-IP4	(*)n/a
Pre-op days for attending physician	ATT IP3	(*)n/a
Prescription drug schedule code	RXS	X
Prescriptions for therapeutic class	RXC	XBBB
Prior authorization	PA	(*)n/a
Prior authorization for procedure	PA-TSP	XBBBBBBBBBB
Procedure	TSP	XBBBBBBBBBB
Provider specialty	PSP	999
Provider specialty for procedure	PSP-TSP	999-XBBBBBBBBBB
Provider type	PVT	999
Provider type for procedure	PVT-TSP	99-XBBBBBBBBBB
Readmission	RA	(*)n/a
Referring physician for procedure	RPH-TSP	XBBBBBBBBBB
Referring/Prescribing physician for therapeutic class	RPH-RXC	XBBB
Referring/Prescribing physician for drug refill	RPH-DR	(*)n/a
Referring/Prescribing physician for therapeutic class drug refill	RPH-RXC-DR	XBBB
Same day for drug therapeutic class	SMD-RXC	XBBB
Same day for place of service and procedure	SMD-POS-TSP	99-XBBBBBBBBBB
Same day for procedure	SMD-TSP	XBBBBBBBBBB
Same day same drug	SD	(*)n/a
Secondary diagnosis	SDGN	AAXAAA
Sex and age for beneficiary	SEX-AGE	S-999
Sex and age for beneficiary	SEX-AGE	S-999
Sex and age for diagnosis	SEX-AGE-DGN	S-999-AAXAAA
Sex and age for diagnosis and procedure	SEX-AGE-DGN-TSP	S-999-AAXAAA-XBBBBBBBBBB
Sex and age for modifier and procedure	SEX-AGE-MOD-TSP	S-999-XX-XBBBBBBBBBB
Sex and age for place of service	SEX-AGE-POS	S-999-99

Table 7.49 – Line Item Description

DATA TYPE	DATA TYPE CODE	CODE FORMAT
Sex and age for place of service and diagnosis and procedure	SEX-AGE-POS-DGN-TSP	S-999-99-AAXAAA-XBBBBBBBBBB
Sex and age for place of service and procedure	SEX-AGE-POS-TSP	S-999-99-XBBBBBBBBBB
Sex and age for procedure	SEX-AGE-TSP	S-999-XBBBBBBBBBB
Surgical discharges	IP2	(*)n/a
Therapeutic leave days	TLD (**)	999
Type of admission	TOA	9
Type of admission for admit day of week	TOA-ADM-DOW	9-DDD
Type of admission for diagnosis	TOA-DGN	9-AAXAAA
Type of admission for discharge day of week	TOA-DSC-DOW	9-DDD
Type of admission for procedure	TOA-TSP	9-XBBBBBBBBBB
*Standard extract codes are denoted with an asterisk and "n/a" in the code format field.		
** Accumulator code 1 for HLD and TLD will accumulate the number of days for leave days.		

Table 7.50 – Code Format Key

Code	Description
9	Value must be 0-9
A	Value must be 0-9, A-Z, imbedded blanks
B	Value must be 0-9, A-Z, trailing blanks
D	Value must be MON, TUE, WED, THU, FRI, SAT, SUN
S	Value must be M or F
X	Value must be 0-9, A-Z
-	Value must be a dash

Maintenance of Summary Line Item Control File

The user must define the contents and layout of the summary profiles by coding and entering two sets of input for each different report layout desired. If the multiple report per category of service option is user, two additional types of input must be coded for each report definition including the "default" report which will be used for provider specialties or beneficiary aid categories not assigned to a specific report sequence.

Extract Definition Inputs

Define the data to be extracted and accumulated from the history file. There are three types of extract definition inputs:

1. Type A -Defines the specialty/aid category groups assigned to a report sequence. The Type A should only be coded when the multiple report option is used. There are two Type A formats; one for providers and one for beneficiaries. Only one Type A is input for each report sequence.

2. Type D -Gives a verbal description of the data to be extracted within a major/minor category code. One D input must be coded for each category code referenced on the extract definition E input.

3. Type E -Defines the extract data type and detail codes for each and assigns the extract values to the two-digit category code. All extract data which will be accumulated as one unit is assigned to the same category code. There can be any number of E inputs for each category code used. The specific data to be accumulated (services, billed, paid, etc.) is taken from the report definition inputs.

Report Definition Inputs

Define the layout of the reports, the way in which the extracted data is to be combined to arrive at the line item values, and exception limits. There are three input types which may be coded in the report definition input set.

1. Type A -Defines the specialty/aid category groups assigned to a report sequence. One A input is coded per report sequence only when the multiple report option is used. There is a separate A input for providers and beneficiaries. The two A inputs for a report sequence extract definition and report definition must match exactly.

2. Type D -Defines the actual verbiage to be used as the line item description on the report. Exception limits which apply to a line, forced exception indicators, and title lines are also indicated on the D input.

3. Type E -Defines the category codes, accumulation codes, and the equation to be used in computing the value of each line item. This card can have two different formats depending on whether the user wants to code his own equation or he uses one of the formula codes from the table.

Examples of the window used for summary profile criteria input/maintenance, and the resulting Reports generated follow, with corresponding field descriptions of each.

Window Definition: SUR Summary Profile Maintenance

Introduction

The Summary Profile Line Item Control File Windows controls the data to be reported within the Provider and Beneficiary summary profile functions.

The SUR Summary Profile Maintenance Window is used to gain access to the following function:

Define and update provider specialty A cards for report image assignment

Define and update recipient aid category A cards for report image assignment

Access report definition D and E card windows

Access extract definition D and E card windows

The SUR Summary Profile Maintenance Window will be accessed utilizing the mouse by clicking the Summary Profile (40 File) button on the SUR Main Menu, or by pressing ALT + 4 on the keyboard.

Detailed Field Information

Table 7.51 – Field Description

Field	Description
FIELD NAME:	SUBSYS
DESCRIPTION:	The subsystem that the user wishes to access. The user must select either provider or recipient.
FORMAT:	Provider or Recipient
FEATURES:	Drop down list box
	Valid values:
	Prov
	Recip
EDITS:	Value required for this item.
TO CORRECT:	The user must select whether a change, addition, or deletion will effect provider or recipient summary extract cards.
FIELD NAME:	COS
DESCRIPTION:	The SURS category of service that the user wishes to access
FORMAT:	00 UNUSED
	01 INPATIENT
	03 OUTPATIENT
	04 PCCM
	05 RBMC
	06 PHYSICIAN
	07 PHARMACY
	08 SUPPLIERS
	11 LAB/XRAY/SPLT. CLINIC
	13 TRANSPORTATION/SP SVC
	14 LONG TERM CARE
	20 THERAPY SERVICES
	22 MENTAL HEALTH
	23 DENTAL/OPTOMETRIC
	33 WAIVER PROGRAMS
FEATURES:	Drop down list box
EDITS:	80034 - Category of Service must be selected for providers.

Table 7.51 – Field Description

Field	Description
TO CORRECT:	Choose the category of service to modify.
FIELD NAME:	REPORT SEQ
DESCRIPTION:	Within each COS, nine different sets of line items (report sequences) are available. The ninth set, Z, is considered the 'default' activity summary and applies to all providers in the COS whose specialty is not specified elsewhere.
FORMAT:	A, B, C, D, E, F, G, H, Z
FEATURES:	Drop down list box
EDITS:	80035 - Report Sequence must be selected.
TO CORRECT:	Choose the appropriate report sequence.
FIELD NAME:	SPECIALTIES: 1-5
DESCRIPTION:	The cross-reference specialty codes to be reported in the selected report sequence for the COS
FORMAT:	4 character alphanumeric
FEATURES:	None
EDITS:	Data Window Error - Item 'X' does not pass the validation test.
	(where 'X' = the value keyed)
TO CORRECT:	Verify and key a valid 4 digit specialty cross-reference code.

Table 7.52 – Other messages / edits:

Message	Edit
"Save successful"	Save button
"Save unsuccessful"	Save button
"Do you really want to delete this record?"	Delete button
"Delete successful"	Delete button
"Delete unsuccessful"	Delete button
"Continue without saving?"	Exit button

Report Definition: SUR-0400-Q, and SUR-0500-Q and Extract Definition Edit

Part I Report Definition Information

Functional Area:	SURS
Report Number:	SUR-0400-Q
	SUR-0500-Q
Job Name:	SRGJQ040
Report Title:	Extract Definition Edit Report

Description of Information

The Extract Definition Edit Report (SUR-0400-Q for recipients, SUR-0500-Q for providers) lists the extract definition inputs and any associated error messages.

Purpose of Report

The Extract Definition Edit Report provides a means to verify the entry of summary extract input formats. Any errors identified must be corrected and a "clean" edit report produced before the quarterly cycle can commence.

Sort Sequence

Category of service, report sequence, category code, input type

Distribution

Distribution	Media	Copies	Frequency
EDS	Paper	1 copy	Quarterly and on request

Extract Definition Edit

Part II Report Definition Information

Functional Area:	SURS
Report Number:	SUR-0400-Q SUR-0500-Q

Detailed Field Definitions

Table 7.53 – Field Description

Field	Description
Run Date	The date the report was produced
Report Sequence	Indicates the report sequence when the multiple report option is used.
Category of Service	The SURS category of service of the profile line item scheme reported
Period	The current cycle period
Specialties / Aid Categories	For provider reports, the specialty groups included in the report sequence. For beneficiary reports, the aid category groups for the report sequence. This applies only when the multiple report option is used.
Card Image	The exact image of the extract definition inputs
Error Messages	Describes any errors detected during the edit process. If none were found on the input, this is also indicated.

Table 7.54 – Footings

Field	Description
Cards Read	The number of inputs acknowledged by the system
Cards Accepted	The number of inputs that passed all edits
Cards Rejected	The number of inputs that failed one or more edits
Edit Messages	The number of warning messages displayed on the edit report

If no errors were encountered in the report sequence, a message "File Was Created" appears. Otherwise, the message "File Was Not Created" is printed, indicating that the user must correct the errors before the file will be created for cycle generation.

Report Example: Extract Definition Edit

```
  REPORT:   SUR-0400-Q                                INDIANAAIM                                          PAGE:    99,999
 PROCESS:   SRGJQ040                                                                                     RUN DATE: MM/DD/CCYY
LOCATION:   SRGP0402                  INDIANA MEDICAID MANAGEMENT INFORMATION SYSTEM                     RUN TIME: 11:50:06

                                    RECIPIENT EXTRACT DEFINITION EDIT REPORT                  PERIOD: MM/CCYY THRU MM/CCYY

REPORT SEQUENCE – X                                                                AID CATEGORIES - XXXXXXX
------------------------------CARD IMAGE-----------------------------------------
00000000011111111112222222222333333333344444444455555555556666666666777777777 8
12345678901234567890123456789012345678901234567890123456789012345678901234567890 ------------------ ERROR MESSAGES -----------------

IN9BXT A  A AGED                                                                                          ** NO ERRORS **

        RECIPIENT AID CROSS REFERENCE DESCRIPTION
        AGED –AGED RECIPIENTS

IN9BXT A  D  11         Physicians                                                                        ** NO ERRORS **
IN9BXT A  E  11  PVT                                                                                      ** NO ERRORS **
IN9BXT A  E  031                        031

IN9BXT A  D  11         Chiropractors                                                                     ** NO ERRORS **
IN9BXT A  E  11  PVT                                                                                      ** NO ERRORS **
IN9BXT A  E  015                        015

IN9BXT A  D  11         Pharmacies                                                                        ** NO ERRORS **
IN9BXT A  E  11  PVT                                                                                      ** NO ERRORS **
IN9BXT A  E  024                        024

IN9BXT A  D  11         Transportation                                                                    ** NO ERRORS **
IN9BXT A  E  11  PVT                                                                                      ** NO ERRORS **
IN9BXT A  E  026                        026

IN9BXT A  D  11         Dentists                                                                          ** NO ERRORS **
IN9BXT A  E  11  PVT                                                                                      ** NO ERRORS **
IN9BXT A  E  027                        027

IN9BXT A  D  11         Optometrists                                                                      ** NO ERRORS **
IN9BXT A  E  11  PVT                                                                                      ** NO ERRORS **
IN9BXT A  E  018                        019
                                  TOTAL CARDS READ        999,999
                                   TOTAL CARDS ACCEPTED    999,999
                                  TOTAL CARDS REJECTED    999,999
                                  TOTAL ERROR MESSAGES    999,999
                                     *****FILE WAS CREATED*****
                                              CUSTOMER APPROVAL BY _____________________  DATE _________
```

Report Example: Extract Definition Edit

```
  REPORT:   SUR-0500-Q                                INDIANAAIM                                PAGE:    99,999
 PROCESS:   SRGJQ040                                                                          RUN DATE: MM/DD/CCYY
LOCATION:   SRGP0402                  INDIANA MEDICAID MANAGEMENT INFORMATION SYSTEM          RUN TIME: 11:50:06

                                        PROVIDER EXTRACT DEFINITION EDIT REPORT            PERIOD: MM/CCYY THRU MM/CCYY

REPORT SEQUENCE - X                CATEGORY OF SERVICE - 33 - WAIVER PROGRAMS         SPECIALTES - XXXXXXX

-------------------------------CARD IMAGE-----------------------------------------
00000000011111111112222222222333333333344444444455555555556666666666777777777 8
12345678901234567890123456789012345678901234567890123456789012345678901234567890 ------------------ ERROR MESSAGES -----------------

IN9PXT01A  E 15 DSC-DOW                                                                          ** NO ERRORS **
IN9PXTO1A  E SUN                        SUN                                                      ** NO ERRORS **

IN9PXT01A  D 21          1 day stay                                                              ** NO ERRORS **
IN9PXTO1A  E 21 LOS                                                                              ** NO ERRORS **
IN9PXTO1A  E 001

IN9PXT01A  D 22          2 day stay                                                              ** NO ERRORS **
IN9PXTO1A  E 22 LOS                                                                              ** NO ERRORS **
IN9PXTO1A  E 002                        001

IN9PXT01A  D 23          31+ day stay                                                            ** NO ERRORS **
IN9PXTO1A  E 23 LOS                                                                              ** NO ERRORS **
IN9PXTO1A  E 031                        998

IN9PXT01A  D 31          Transfers out                                                           ** NO ERRORS **
IN9PXTO1A  E 31 DCS                                                                              ** NO ERRORS **
IN9PXTO1A  E 02                         01

                                      TOTAL CARDS READ        999,999

                                      TOTAL CARDS ACCEPTED    999,999

                                      TOTAL CARDS REJECTED    999,999

                                      TOTAL ERROR MESSAGES    999,999
                                         *****FILE WAS CREATED*****

                                                  END OF REPORT
```

Report Definition: SUR-0410-Q, and SUR-0510-Q, Report Definition Edit

Part I Report Definition Information

Functional Area:	SURS
Report Number:	SUR-0410-Q SUR-0510-Q
Job Name:	SRGJQ040
Report Title:	Report Definition Edit Report

Description of Information on the Report:

The Report Definition Edit Report (SUR-0510-Q for providers, SUR-0410-Q for recipients) lists the report definition inputs and any associated error messages.

Purpose of Report

The Report Definition Edit Report provides a means to verify the entry of summary report input formats. Any errors identified must be corrected and a "clean" edit report produced before the quarterly cycle can commence.

Sort Sequence

Category of service, report sequence, category code, input type

Distribution

Distribution	Media	Copies	Frequency
EDS	Paper	1 copy	Quarterly and on request

Report Definition Edit

Part II Report Definition Information

Functional Area:	SURS
Report Number:	SUR-0410-Q
	SUR-0510-Q

Detailed Field Definitions

Table 7.55 – Field Description

Field	Description
Run Date	The date the report was produced
Period	The current cycle period
Specialty / Aid Category Cross Reference	For provider reports, the specialty groups included in the report sequence. For beneficiary reports, the aid category groups for the report sequence. This applies only when the multiple report option is used.
Card Image	The exact image of the report definition inputs
Error Messages	Describes any errors detected during the edit process. If none were found on the input, this is also indicated.

Table 7.56 – Footings

Field	Description
Cards Read	The number of inputs acknowledged by the system
Cards Accepted	The number of inputs that passed all edits
Cards Rejected	The number of inputs that failed one or more edits
Edit Messages	The number of warning messages displayed on the edit report

If no errors were encountered in the report sequence, a message "File Was Created" appears. Otherwise, the message "File Was Not Created" is printed, indicating that the user must correct the errors before the file will be created for cycle generation.

Report Example: Report Definition Edit

```
  REPORT:   SUR-0410-Q                                  INDIANAAIM                                          PAGE:    99,999
 PROCESS:   SRGJQ040                                                                                       RUN DATE: MM/DD/CCYY
LOCATION:   SRGP0402                  INDIANA MEDICAID MANAGEMENT INFORMATION SYSTEM                       RUN TIME: 11:50:06

                                        RECIPIENT EXTRACT DEFINITION EDIT REPORT                  PERIOD: MM/CCYY THRU MM/CCYY

REPORT SEQUENCE – X                                                                AID CATEGORIES - XXXXXXX

------------------------------CARD IMAGE----------------------------------------
00000000011111111112222222222333333333344444444455555555566666666677777777778
12345678901234567890123456789012345678901234567890123456789012345678901234567890 ------------------ ERROR MESSAGES -----------------

IN9BRP A  A AGED                                                                                          ** NO ERRORS **

         RECIPIENT AID CROSS REFERENCE DESCRIPTION
         AGED –AGED RECIPIENTS

IN9BRP A01D  Amt Billed                                                                                   ** NO ERRORS **

IN9BRP AO1E  100 MD2                                                                                      ** NO ERRORS **

IN9BRP A02D  Amt Paid                                                                                     ** NO ERRORS **

IN9BRP AO2E  100 MD4                                                                                      ** NO ERRORS **

IN9BRP A03D  Pct Paid of Billed                                                                           ** NO ERRORS **

IN9BRP AO3E  105 MD4 MD2                                                                                  ** NO ERRORS **

IN9BRP A04D  No Claims                                                                                    ** NO ERRORS **

IN9BRP AO4E  100 MD5                                                                                      ** NO ERRORS **

IN9BRP A05D  Avg Amt Paid/Claim     050                                                                   ** NO ERRORS **

                                          TOTAL CARDS READ        999,999

                                          TOTAL CARDS ACCEPTED    999,999

                                          TOTAL CARDS REJECTED    999,999

                                          TOTAL ERROR MESSAGES    999,999
                                             *****FILE WAS CREATED*****
                                               END OF REPORT
```

Report Example: Report Definition Edit

```
  REPORT:   SUR-0510-Q                                  INDIANAAIM                                          PAGE:    99,999
 PROCESS:   SRGJQ040                                                                                       RUN DATE: MM/DD/CCYY
LOCATION:   SRGP0402                    INDIANA MEDICAID MANAGEMENT INFORMATION SYSTEM                      RUN TIME: 11:50:06

                                        PROVIDER REPORT DEFINITION EDIT REPORT                  PERIOD: MM/CCYY THRU MM/CCYY

REPORT SEQUENCE – X                   CATEGORY OF SERVICE – 01 – INPATIENT                 SPECIALTES – S010
--------------------------------CARD IMAGE-----------------------------------------
0000000001111111112222222222333333333344444444455555555566666666677777777778
1234567890123456789012345678901234567890123456789012345678901234567890123456789 ------------------ ERROR MESSAGES -----------------

IN9BRP A  A AGED                                                                                          ** NO ERRORS **

         SPECIALTY CROSS REFERENCE DESCRIPTION
         S010-ACUTE CARE HOSPITAL
IN9BRP01A01D  Amt Billed                                                                                  ** NO ERRORS **

IN9BRP01AO1E  100 MD2                                                                                     ** NO ERRORS **

IN9BRP01A02D  Amt Paid                                                                                    ** NO ERRORS **

IN9BRP01AO2E  100 MD4                                                                                     ** NO ERRORS **

IN9BRP01A03D  Pct Paid of Billed                                                                          ** NO ERRORS **

IN9BRP01AO3E  105 MD4 MD2                                                                                 ** NO ERRORS **

IN9BRP01A04D  No Claims                                                                                   ** NO ERRORS **

IN9BRP01AO4E  100 MD5                                                                                     ** NO ERRORS **

IN9BRP01A05D  Avg Amt Paid/Claim     050                                                                  ** NO ERRORS **

                                          TOTAL CARDS READ        999,999

                                          TOTAL CARDS ACCEPTED    999,999

                                          TOTAL CARDS REJECTED    999,999

                                          TOTAL ERROR MESSAGES    999,999
                                             *****FILE WAS CREATED*****
                                                       END OF REPORT
```

Report Definition: SUR-0430-Q, and SUR-0530-Q Summary Line Definitions

Part I Report Definition Information

Functional Area:	SURS
Report Number:	SUR-0430-Q
	SUR-0530-Q
Job Name:	SRGJQ040
Report Title:	Summary Line Definitions Report

Description of Information

The Summary Line Definitions Report displays extract definition and report definition inputs, combined, to create a total reference to the data to be accumulated for each summary profile line item.

Purpose of Report

The Summary Line Definitions Report relates the extract and report definition inputs for each report sequence to give the user a picture of what is included in each equation in terms of the extract criteria and data accumulated. The expanded equation is displayed so that his may be reviewed along with the operand contents to determine accuracy and validity of the report values resulting from the data combination. This report will be produced only if there were no errors on any of the extract or report definition inputs defining the summary report.

Sort Sequence

Category of service, report sequence, summary line item number

Distribution

Distribution	Media	Copies	Frequency
IFSSA	Paper	1 copy	Quarterly
EDS	Paper	1 copy	Quarterly and on request

Summary Line Definitions

Part II Report Definition Information

Functional Area: SURS

Report Number: SUR-0530-Q

Detailed Field Definitions

Table 7.57 – Field Description

Field	Description
Run Date	The date the report was produced
Report Sequence	Indicates the report sequence when the multiple report option is used.
Category of Service	The SURS category of service of the profile line item scheme reported
Specialties / Aid Categories	For provider reports, the specialty groups included in the report sequence. For beneficiary reports, the aid category groups for the report sequence. This applies only when the multiple report option is used.
Line Number	The line number assigned to the line
Line Description	The verbiage to appear in the summary section of the report
Line Limits / Forced Exception Indicator	Displays the type and value of exception limits, if applied. Forced exception lines are also indicated.
Line Equation	The algebraic equation as interpreted from the formula code and operands specified by the user.
Operand	Each operand used in the equation is shown with the following information:
Extract Code	Identifies the type of data being accumulated. If a standard code is used this field is blank.
Accumulator	The literal interpretation of the accumulator code.
From Value	The user supplied detail code which represents the from value of the code range to be reported. This field is blank when a standard code is used.
To Value	The user supplied detail code which represents the to value of the code range to be reported. This field is blank when a standard code is used.
Description	User supplied description of the detail codes. In the case of standard codes, the description is system generated.

Report Example: Summary Line Definitions

```
  REPORT:   SUR-0430-Q                                  INDIANAAIM                                                PAGE:    99,999
 PROCESS:   SRGJQ040                                                                                             RUN DATE: MM/DD/CCYY
LOCATION:   SRGP0402                     INDIANA MEDICAID MANAGEMENT INFORMATION SYSTEM                          RUN TIME: 11:50:06

                                        RECIPIENT SUMMARY LINE DEFINITION REPORT                  PERIOD: MM/CCYY THRU MM/CCYY

REPORT SEQUENCE – X                                                                    AID CATEGORIES - XXXX

------------------- LINE NO  --------- LINE DESCRIPTION  ---------- LINE LIMITS/FORCED INDICATOR -------------------------

                      01      Amt Billed

    LINE EQUATION IS: MD2

  LINE WEIGHT MULTIPLIER IS   1

  OPERAND  EXTRACT CODE            ACCUMULATOR     FROM VALUE                  TO VALUE                          COS   DESCRIPTION

    MD2                              BILLED                                                                      ALL MEDICAID

 ------------------- LINE NO  --------- LINE DESCRIPTION  ---------- LINE LIMITS/FORCED INDICATOR -------------------------

                      02      Amt Billed

    LINE EQUATION IS: MD4

  LINE WEIGHT MULTIPLIER IS   1

  OPERAND  EXTRACT CODE            ACCUMULATOR     FROM VALUE                  TO VALUE                          COS   DESCRIPTION

    MD4                              PAID                                                                      ALL MEDICAID



                                                 CUSTOMER APPROVAL BY_________________DATE________

                                                END OF REPORT
```

Report Example: Summary Line Definitions

```
  REPORT:   SUR-0530-Q                              INDIANAAIM                                  PAGE:    99,999
 PROCESS:   SRGJQ040                                                                           RUN DATE: MM/DD/CCYY
LOCATION:   SRGP0402                 INDIANA MEDICAID MANAGEMENT INFORMATION SYSTEM            RUN TIME: 11:50:06

                                       PROVIDER SUMMARY LINE DEFINITION REPORT              PERIOD: MM/CCYY THRU MM/CCYY

REPORT SEQUENCE – X                  CATEGORY OF SERVICE – 01 – INPATIENT                SPECIALTES – S010

------------------- LINE NO  --------- LINE DESCRIPTION  ---------- LINE LIMITS/FORCED INDICATOR -------------------------

                     01      Amount Billed

    LINE EQUATION IS: MD2

  LINE WEIGHT MULTIPLIER IS   1

  OPERAND  EXTRACT CODE            ACCUMULATOR     FROM VALUE                  TO VALUE                          COS   DESCRIPTION

    MD2                              BILLED                                                                      ALL MEDICAID

 ------------------- LINE NO  --------- LINE DESCRIPTION  ---------- LINE LIMITS/FORCED INDICATOR -------------------------

                     02      Amount Billed

    LINE EQUATION IS: MD4

  LINE WEIGHT MULTIPLIER IS   1

  OPERAND  EXTRACT CODE            ACCUMULATOR     FROM VALUE                  TO VALUE                          COS   DESCRIPTION

    MD4                              PAID                                                                      ALL MEDICAID



                                                 CUSTOMER APPROVAL BY_________________DATE________

                                                END OF REPORT
```

Deselection of Provider and/or Recipient Control

Providers and beneficiaries may be eliminated from summary profile exception processing if desired by the user. The deselected participant's activity will be included on their peer group reports and on the All Summary Profiles, if one is produced. However, the participant will not appear on the Exception Summary Profile Report and will not be ranked.

Maintenance of Deselection of Provider and/or Recipients Control

Providers who were reviewed by the SUR Unit during the previous four quarters, or who are known to be currently under investigation by the Indiana Fraud Control Unit are deselected from exception processing. Recipients who were reviewed by the SUR Unit during the previous four quarters, or who are currently sanctioned to the Restricted Card Program are deselected from exception processing.

The Medicaid provider number and Medicaid recipient identification of those individuals to be deselected are entered on the SUR Provider and Recipient Deselection Windows prior to quarterly cycle generation.

An example of the windows used for provider and recipient deselection with corresponding field descriptions follows.

Window Definition: SUR Provider Deselection

Introduction

The Surveillance and Utilization Review (SUR) Provider Deselection Window provides a method for eliminating previously targeted providers from exception processing and rank reporting, allowing new cases to surface. The Medicaid provider number of those individuals to be deselected is entered on the SUR Provider Deselection Window prior to quarterly cycle generation.

The SUR Provider Deselection Window will be accessed utilizing the mouse by clicking the Provider Deselect (70) File button on the SUR Main Menu or by pressing ALT + 7 on the keyboard.

Detailed Field Information

Table 7.58 – Field Description

Field	Description
FIELD NAME:	TOTAL RECORDS
DESCRIPTION:	The total number of records that are carried on the file
FORMAT:	4 digit, numeric
FEATURES:	System generated

Table 7.58 – Field Description

Field	Description
EDITS:	None
TO CORRECT:	N/A
FIELD NAME:	PROVIDER NUMBER
DESCRIPTION:	The Medicaid identification number of the provider
FORMAT:	9 digit, numeric
FEATURES:	None
EDITS:	Should be 9 characters.
TO CORRECT:	Verify keying and enter valid 9 digit, numeric provider number.
FIELD NAME:	DATE
DESCRIPTION:	A field that may be used to enter the date of deselection, or other reference date, as specified by the user
FORMAT:	CCYYMMDD, or blank
FEATURES:	None
EDITS:	Data Window Error - Item 'X' does not pass the validation test
	(where 'X' = the value keyed)
TO CORRECT:	Enter date in CCYYMMDD format.
FIELD NAME:	COMMENT
DESCRIPTION:	A free form field that may be used to enter any additional comments regarding the entry
FORMAT:	Alpha numeric
FEATURES:	None
EDITS:	None
TO CORRECT:	N/A
FIELD NAME:	INQUIRE PROVIDER ID and BUTTON
DESCRIPTION:	A provider number may be entered in the Inquire Provider ID field and located in the file when the Inquire Button is clicked with the mouse. All records on file are displayed when the Inquire Button is clicked and the Provider ID field is left blank.
FORMAT:	9 digit, numeric
FEATURES:	Systematic location of inquire key
EDITS:	80031 - Provider not found.
TO CORRECT:	Verify keying and re-enter provider number, select another provider on which to inquire, or delete the entry.

Table 7.59 – Other messages / edits:

Message	Edit
"Save successful"	Save button
"Save unsuccessful"	Save button
"Delete successful"	Delete button
"Delete unsuccessful"	Delete button
"Continue without saving?"	Exit button
"Sort order is required"	Sort button

Window Example: SUR Provider Deselection

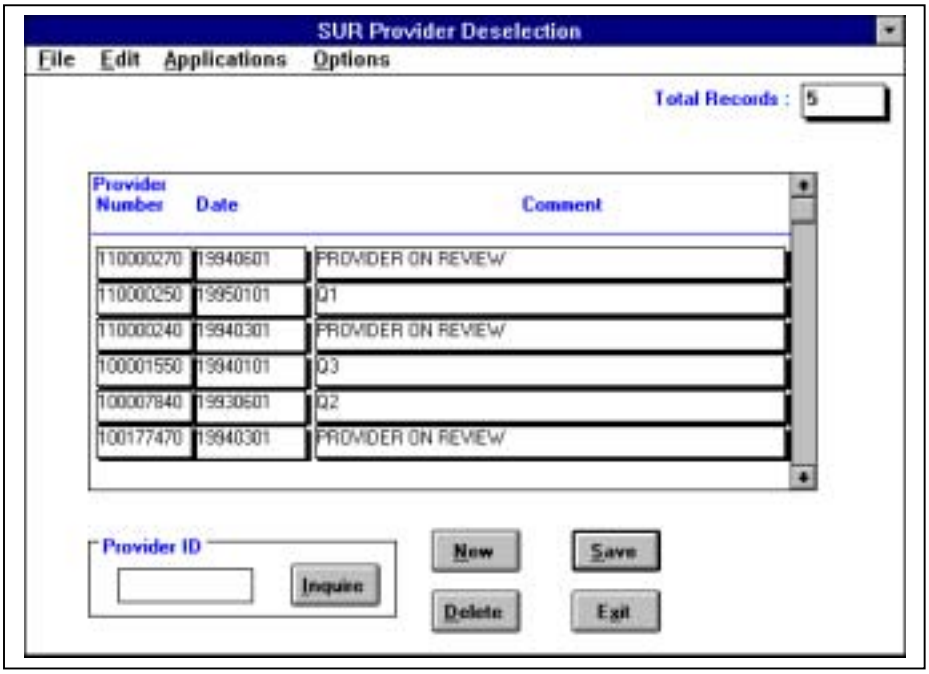

Figure 10

Window Definition: SUR Recipient Deselection

Introduction

The Recipient Deselection Control File provides a method for eliminating previously targeted recipient from exception processing and rank reporting, allowing new cases to surface. The Medicaid recipient

number of those individuals to be deselected is entered on the SUR Recipient Deselection Window prior to quarterly cycle generation.

The SUR Recipient Deselection Window will be accessed utilizing the mouse by clicking the Recipient Deselect button on the SUR Main Menu. The window may also be accessed using the keyboard by pressing ALT + R.

Detailed Field Information

Table 7.60 – Field Description

Field	Description
FIELD NAME:	TOTAL RECORDS
DESCRIPTION:	The total number of records that are displayed on the window
FORMAT:	4 digit, numeric
FEATURES:	System generated
EDITS:	None
TO CORRECT:	N/A
FIELD NAME:	RECIPIENT NUMBER
DESCRIPTION:	The identification number of the recipient
FORMAT:	12 digit, numeric
FEATURES:	None
EDITS:	80041 -Recipient Not Found
TO CORRECT:	The recipient number keyed is not on the recipient table. Verify keying and enter valid 12 digit, numeric recipient number.
FIELD NAME:	DATE
DESCRIPTION:	A field that may be used to enter the date of deselection, or other reference date, as specified by the user
FORMAT:	CCYYMMDD, or blank
FEATURES:	None
EDITS:	91001 - Invalid date (CCYYMMDD)!
TO CORRECT:	Enter date in CCYYMMDD format.
FIELD NAME:	COMMENT
DESCRIPTION:	A free form field that may be used to enter any additional comments regarding the entry
FORMAT:	Alpha numeric
FEATURES:	None
EDITS:	None
TO CORRECT:	N/A
FIELD NAME:	INQUIRE RECIPIENT ID and BUTTON
DESCRIPTION:	A recipient number may be entered in the Inquire Recipient ID field and located in the file when the Inquire Button is clicked with the mouse. All records on file are displayed when the Inquire Button is clicked and the Recipient ID field is left blank.

Table 7.60 – Field Description

Field	Description
FORMAT:	12 digit, numeric
FEATURES:	Systematic location of inquire key
EDITS:	60042 - Invalid Recipient Medicaid ID
TO CORRECT:	Verify keying and enter valid 12 digit, numeric recipient number.
EDITS:	80041 -Recipient Not Found
TO CORRECT:	The recipient number keyed is not on the recipient table. Verify keying and enter valid 12-digit, numeric recipient number.

Table 7.61 – Other messages / edits:

Message	Edit
"Save successful"	Save button
"Save unsuccessful"	Save button
"Delete successful"	Delete button
"Delete unsuccessful"	Delete button
"Continue without saving?"	Exit button
"Sort order is required"	Sort button

Window Example: SUR Recipient Deselection

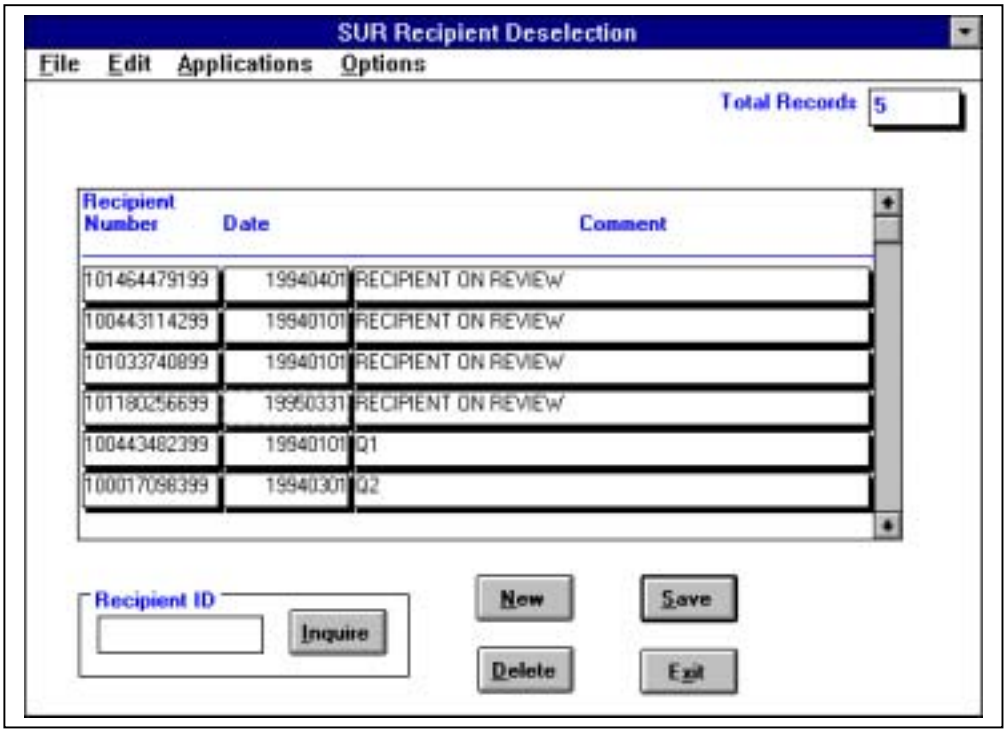

Figure 11

LTC Selection Control

Production of the Long Term Care Reports are controlled by input into the LTC Selection Control File. The user selects the reports to be generated, the providers to be processed and the date of service range to be reported.

Maintenance of LTC Selection Control File

The reporting specifications are input by the SURS Analyst through an on-line window prior to quarterly cycle generation. An example of the window used for LTC selection criteria input/maintenance follows, with corresponding field descriptions.

Window Definition: LTC Provider Select

Introduction

The LTC Provider Select Window provides a method for controlling what reports and providers the Long Term Report series will be produced for the quarterly cycle generation.

The LTC Provider Select Window will be accessed utilizing the mouse by clicking the LTC Select Providers (50 File) button on the SUR Main Menu or ALT + 5 on the keyboard.

Detailed Field Information

Field Name: TOTAL RECORDS

Description – The total number of records that are carried on the file

Format – Four-digit, numeric

Features – System generated

Edits – None

To correct – N/A

Field Name: PROVIDER

Description – The provider ID number for which LTC reports are being selected.

Format – Nine-digit, numeric

Features – None

Edits – Should be nine characters.

To correct – Verify keying and enter valid 9 digit, numeric provider number.

Field Name: FROM DATE

Description – The low date in a range of dates for which the LTC reports selected will be produced.

Format – CCYYMMDD

Features – None

Edits – 91001 - Invalid date (CCYYMMDD)!

To correct – Enter date in CCYYMMDD format.

5048 - Date cannot be future date!

To correct – Enter date = or < present date in CCYYMMDD format.

Field Name: TO DATE

Description – The high date in a range of dates for which the LTC reports selected will be produced.

Format – CCYYMMDD

Features – None

Edits – 91001 - Invalid date (CCYYMMDD)!

To correct – Enter date in CCYYMMDD format.

From Date > To Date

To correct – Enter valid date range where from < to.

Field Name: RPT 610

Description – An X in this field indicates that a LTC Provider Report is selected for the provider.

Format – X

Features – Click to mark X

Edits – None

To correct – N/A

Field Name: RPT 620

Description – An X in this field indicates that a LTC Summary Report is selected for the provider.

Format – X

Features – Click to mark X

Edits – None

To correct – N/A

Field Name: REPORT SRGR 631/632/633

Description – None, one, two, three or any combination of the three reports listed in the drop down list box may be selected for the provider.

Format – 1

2

3

1&2

1&3

2&3

1&2&3

None

Features – Drop down list box

Edits – None

To Correct – N/A

Field Name: REPORT SRGR 634/635/636

Description – None, one, two, three or any combination of the three reports listed in the drop down list box may be selected for the provider.

Format – 4

5

6

4&5

4&6

5&6

4&5&6

None

Features – Drop down list box

Edits – None

To correct – N/A

Field Name: INQUIRE PROVIDER ID and BUTTON

Description – A provider number may be entered in the Inquire Provider ID field and located in the file when the Inquire Button is clicked with the mouse. All records on file are displayed when the Inquire Button is clicked and the Provider ID field is left blank.

Format – Nine digit, numeric

Features – Systematic location of inquire key

Edits – 91011 - Record not found please try again.

To correct – Verify keying and re-enter provider number, select another provider on which to inquire, or delete the entry.

Other Messages/Edits:

"Save successful" – Save button

"Save unsuccessful" – Save button

"Do you really want to delete this record?" – Delete button

"Delete successful" – Delete button

"Delete unsuccessful" – Delete button

"Continue without saving?" – Exit button

"Sort order is required" – Sort button

DRG Control

The DRG control members are used to tailor the DRG reporting system to meet the unique specifications of the state for which they are produced.

Maintenance of the DRG Control Members

Four user defined control file members are available, as described below.

- Peer Group Assignment - Peer group codes and descriptions are assigned to institutional providers. Peer grouping methodology, aside from the traditional "provider type and specialty," may be devised to most suitable reflect provider billing practices.

  FORMAT:

COL 1	COL 11	COL 15
XXXXXXXXX	XXX	XXXXXXXXXXXXXXXXXXXXXXXXXXXXXX

COL 1 – Hospital provider number

COL 11 – Peer group code

COL 15 – Peer group description

- DRG Diagnostic Category/MLOS/STD DEV - Each DRG code to be reported is assigned a standard deviation (STD DEV) and mean length of stay (MLOS) used in length of stay exception computations. These values, based on historical claim data, may be redefined periodically to reflect more recent claim activity in the state.

DRG codes are also cross referenced categorically be diagnostic type for 'Length of Stay by Diagnosis Category and Admitting Physician Report' production.

FORMAT:

COL 1	COL 5	COL 10	COL 23	COL 36
XXX	XXXX	XXX.XXXXXXXX	XXX.XXXXXXXX	XXX.X

COL 1 – DRG code

COL 5 – Diagnostic Category

COL 10 – Mean Length of Stay

COL 23 – Standard Deviation

COL 36 – Percentage value to be compared to for Provider Summary Extract Code 'DRG-MLOS'

(see Summary Profile Control section)

- DRG MED/SURG Cross Reference - Each DRG code to be reported is assigned a "type stay" value, either MED (medical) or SURG (surgical) for 'Merged History' reporting.

FORMAT:	
COL 1	COL 7
XXXXX	XXXX

COL 1 – DRG code, leading zeros

COL 7 – Type of stay category, either MED or SURG

- Ancillary Code Cross-Reference Table - Related ancillary codes may be grouped and cross-referenced to major ancillary categories for effective 'Ancillary Distribution' reporting.

FORMAT:	
COL 1	COL 5
XXX	XXX

COL 1 – Detail ancillary code

COL 5 – Major ancillary category cross-reference value

Section 8: Management Applications of SUR Reports

The information in the SUR reports provides a total picture of Medicaid activity within a state. Summary and detail information can be obtained on individual participants, selected classes of providers and recipients, or for the entire state. This level of information is valuable to Program management for purposes other than utilization review.

In addition to utilization case development, SURS reports can be used to measure the effectiveness of utilization review and Program restriction efforts. Various aspects of the overall Medicaid activity can be researched for budgeting, claims processing analysis, or Program policy development. Listed below are some of the special applications for SURS reports.

Procedure Code Distribution and Statistical Analysis

- Identify non-valid procedure codes being processed through the system
- Compile a list of the most frequently used procedure codes as an aid to front-end claims processing
- Determine number of services and/or amounts billed and allowed within a specified time frame for:
  - individual procedures, such as sterilizations, abortions, deliveries
  - a particular category of service (this information may be useful for budgeting)
  - analyze the impact of procedure code changes on claims processing and on the SUR system (this would be helpful when a major front-end procedure code conversion is done)

Diagnosis Code Distribution and Statistical Analysis

- Measure specific disease occurrences within the state by either number of services or dollar cost to the state
- Identify non-valid diagnosis codes being processed in the system
- Compile a list of the most frequently used diagnosis codes as an aid to front-end claims processing

DRG Distribution and Statistical Analysis Report

Measure specific DRG occurrences within the state, or by facility peer group, by either number of services or dollar cost to the state.

Phase II Reports

- Can be used to document the need for prepayment audits such as:
- Procedure should not occur for this diagnosis (Treatment Criteria Analysis Report)
- Procedure should not occur in this place of service (Treatment Factors Analysis Report)
- Procedure should not occur for patient's age (Treatment Factors Analysis Report)
- Procedure should not occur for this provider type (Treatment Factors Analysis Report)
- Diagnosis should not occur for patient's age or sex (Treatment Factors Analysis Report)

DRG Ancillary Distribution Report

Hospital ancillary services billed, although not paid separately when payment methodology is DRG based, contribute to the DRG reimbursement when the DRG base payments are established and periodically re-established. The DRG Ancillary Distribution Report, peer and statewide totals, may assist in the analysis of facility ancillary charges, by ancillary group, to determine which ancillary groups contribute most to the overall base payment of the DRG.

This glossary defines the universal terms of the Indiana Title XIX program as presented in the Request for Proposals (RFP). The spelling and capitalization is approved by the Office of Medicaid Policy and Planning (OMPP) for use in all documents. Any changes made to the original RFP glossary were made at the request of the OMPP. The terms and definitions in the Indiana Title XIX Common Glossary cannot be changed without contacting the Publications Manager of the Documentation Management Unit who will obtain confirmation and approval from the OMPP. Individual units should include additional terms, as required, in the glossary of their documents.

1115(a) Section of the Social Security Act that allows states to waive provisions of Medicaid law to test new concepts which are congruent with the goals of the Medicaid program. Radical, system-wide changes are possible under this provision. Waivers must be approved by CMS. See also *Health Care Financing Administration, Waiver*.

11971 State form 11971; see *8A.*

1261A Division of Family and Children State Form 1261A, *Certification – Plan of Care for Inpatient Psychiatric Hospital Services Determination of Medicaid Eligibility*

1500 This is a claim form used by participating Indiana Health Coverage Programs (IHCP*)* providers to bill medical and medically related services. See also *CMS-1500.*

1902(a)(1) Section of the Social Security Act that requires state Medicaid programs be in effect "in all political subdivisions of the state". See also *Statewideness.*

1902(a)(10) Section of the Social Security Act that requires state Medicaid programs provide services to people that are comparable in amount, duration and scope. See also *Comparability; Sections 1915(a), (b), and (c); Waiver.*

1902(a)(23) Section of the Social Security Act that requires state Medicaid programs ensure clients have the freedom to choose any qualified provider to deliver a covered service. See also *Freedom of Choice, Section 1915(b), Waiver.*

1902(r)(2) Section of the Social Security Act that allows states to use more liberal income and resource methodologies than those used to determine Supplemental Security Income (SSI) eligibility for determining Medicaid eligibility.

1903(m) Section of the Social Security Act that allows state Medicaid programs to develop risk contracts with health maintenance organizations or comparable entities. See also *Risk Contracts.*

1915(a) Section of the Social Security Act that states requirements for Medicaid.

1915(b) Section of the Social Security Act that allows states to waive Freedom of Choice. States may require that beneficiaries enroll in HMOs or other managed care programs, or select a physician to serve as their primary care case manager. Waivers must be approved by CMS.

1915(c)	Section of the Social Security Act that allows states to waive various Medicaid requirements to establish alternative, community-based services for individuals who qualify to receive services in an ICF-MR, nursing facility or Institution for Mental Disease, or inpatient hospital. Waivers must be approved by CMS. See also *CLASS, HCS, MDCP, CMS, NF, Waiver.*
1915(c)(7)(b)	Section of the Social Security Act that allows states to waive Medicaid requirements to establish alternative, community-based services for individuals with developmental disabilities who are placed in nursing facilities but require specialized services. Waivers must be approved by CMS. See also *CMS, HCS-O, Waiver*.
1929	Section of the Social Security Act that allows states to provide a broad range of home and community care to functionally disabled individuals as an optional state plan benefit. The option can serve only people over 65. In Indiana, individuals of any age may qualify to receive personal care services through Section 1929 if they meet the state's functional disability test and financial eligibility criteria. See also *Home and Community Care*.
450A	Social Evaluation for Long Term Care Admission
450B	Certification by Physician for Long Term Care Services.
590 Program	A State health coverage program for institutionalized persons under the jurisdiction of the Division of Mental Health and Department of Health.
7748	State Form 7748, Medicaid Financial Report
8A	*DPW Form 8A (State Form 11971), Notice to Provider of Member Deductible*. Used to relay member spenddown information to providers when the date of service is the same as the spenddown met date.
AA	Anesthesia Assistant.
AAA	Area Agency on Aging. This agency is a significant element in Home and Community-Based Services Waiver Programs.
AAC	Alternative or Augmentative Communication device.
AAP	American Academy of Pediatrics.
AAS	Atomic absorption spectrophotometer.
ABA	American Banking Association.
ABG	Arterial blood gas.
access	Term used to describe the action of entering and utilizing a computer application.
accommodation charge	A charge used only in institutional claims for bed, board, and nursing care.
accretion	An addition to a file or list. For example: the monthly additions to the Medicare Buy-In List.

ACOG	American College of Obstetricians and Gynecologists.
ACS	Affiliated Computer Services. State Healthcare PBM. Pharmacy Benefits Manager, Drug Rebate Services.
ACSW	Academy of Certified Social Workers.
ADA	American Dental Association.
ADAP	AIDS Drug Assistance Program.
ADC	Adult day care.
adjudicate (claim, credit, adjustment)	To process a claim to pay or deny.
adjustment	(1) A transaction that adjusts and reprocesses a previously processed claim; (2) the contractor adjusts a provider's account by debiting underpayments or crediting overpayments on claims.
adjustment recoupments	Recoupments set up by the adjustments staff on recoup and reprocess transactions. A record of these recoupments is maintained by the Cash Control System until zero balanced.
ADL	Activities of daily living.
Advance Planning Document (APD)	A planning guide the federal government requires when a state is requesting 90 percent funding for the design, development, and implementation of an MMIS.
AFDC	Aid to Families with Dependent Children is replaced by Temporary Assistance to Needy Families (TANF).
AG	Attorney General.
Aged and Medicare-Related Coverage Group	Needy individuals who have been designated by Department of Human Services (DHS) as medical assistance members, who are 65 years old or older, or members under any other category who are entitled to benefits under Medicare.
AHF	Antihemophiliac factor.
aid category	A designation within the State Social Services Department under which a person may be eligible for public assistance and/or medical assistance.
Aid to Families with Dependent Children (AFDC)	Needy families with dependent children eligible for benefits under the Medicaid Program, Title IV-A, Social Security Act. Replaced by Temporary Assistance to Needy Families (TANF).
Aid to the Blind (AB)	A classification or category of members eligible for benefits under the IHCP.
AIDS	Acquired Immune Deficiency Syndrome.
AIM	Advanced Information Management.

ALJ	Administrative Law Judge.
allowed amount	Either the amount billed by a provider for a medical service, the Department's established fee, or the reasonable charge, whichever is the lesser figure.
alpha	A field of only alphabetical letters.
alphanumeric	A field of numbers and letters.
ALS	Advanced life support.
ambulance service supplier	A person, firm or institution approved for and participating in Medicare as an air, ground, or host ambulance service supplier or provider.
amount, duration, and scope	How an IHCP benefit is defined and limited in a state's Medicaid plan. Each state defines these parameters, thus state Medicaid plans vary in what is actually covered.
ancillary charge	A charge, used only in institutional claims, for any item except accommodation fees. Examples include drug, laboratory and x-ray charges.
APS	Adult Protective Services.
ARC	Association of Retarded Citizens.
ARCH	Aid to Residents in County Homes. A State-funded program that provides medical services to certain residents of county nursing homes.
Area Agency on Aging	Also known as AAA. This agency is a significant element in Home and Community-Based Services Waiver Programs.
Area Prevailing Charge	Under Medicare Part B, the charge level that on the basis of statistical data would cover the customary charges made for similar services in the same locality.
ASC	Ambulatory Surgery Center.
AT	Action Team.
Attending Physician	The physician providing specialized or general medical care to a member.
Auditing Contractor	The entity under contract with the Office of Medicaid Policy and Planning (OMPP) to conduct audits of long-term-care facilities or other functions and activities as designated by OMPP.
auto assignment	Indiana*AIM* process that automatically assigns a managed care member to a managed care provider if the member does not select a provider within a specified time frame.
Automated Voice Response (AVR)	Computerized voice response system that helps providers obtain pertinent information concerning member eligibility, benefit limitation, check information, and prior authorization (PA) for those participating in the IHCP.

Average Wholesale Price; used in reference to drug pricing.	Indiana*AIM* process that automatically assigns a managed care member to a managed care provider if the member does not select a provider within a specified time frame.
AVR	Automated voice-response system used by providers to verify member eligibility by phone.
AWP	Average wholesale price used for drug pricing.
banner page	Brief messages sent to providers with the weekly remittance advices (RAs).
behavorial health care	Assessment and treatment of mental and/or psychoactive substance abuse disorders.
BENDEX	Beneficiary Data Exchange. A file containing data from CMS about persons receiving Medicaid benefits from the Social Security Administration.
Beneficiary	One who benefits from program such as the IHCP. Most commonly used to refer to people enrolled in the Medicare program.
benefit	A schedule of health care service coverage that an eligible participant in the IHCP receives for the treatment of illness, injury, or other conditions allowed by the State.
benefit level	Limit or degree of services a person is entitled to receive based on his or her contract with a health plan or insurer.
bidder	Any corporation, company, organization, or individual that responds to a Request for Proposal (RFP).
bill	A statement of charges for medical services, the submitted claim document, or electronic record; which may contain one or more services performed.
billed amount	The amount of money requested for payment by a provider for a particular service rendered.
billing provider	The party responsible for submitting to the department the bills for services rendered to an IHCP member.
billing service	An entity under contract with a provider that prepares billings on behalf of the provider for submission to payers.
block	Specific area on a claim or worksheet containing claim information.
BLS	Basic Life Support.
Blue Book	The *American Druggist Blue Book*, used as a reference in pricing drug products.

Boren Amendment	An amendment to *OBRA 80 (P.O. 96-499)*, which repealed the requirement that states follow Medicare principles in reimbursing hospitals, nursing facilities (NF) and intermediate care facility for the mentally retarded (ICF/MR) under the IHCP. The amendment substituted language that required states to develop payment rates that were "reasonable and adequate" to meet the costs of "efficiently and economically operated" providers. Boren was intended to give states new flexibility but it has increased successful lawsuits by providers and thus has contributed to the rising cost of Medicaid-funded institutional care.
BQAMIS	Bureau of Quality Assurance Management Information System.
BSN	Bachelor of Science in Nursing.
BSW	Bachelor of Social Work.
budgeted amount	The planned expenditures for a given time period.
bulletins	Informational directives sent to providers of IHCP services containing information on regulations, billing procedures, benefits, processing, or changes in existing benefits and procedures.
buy-in	A procedure whereby the State pays a monthly premium to the Social Security Administration on behalf of eligible IHCP members, enrolling them in Medicare Part A or Part B or both programs.
C&T	Certification and Transmittal; a document from the Indiana State Department of Health (ISDH).
C519	Authorization for Member Liability Deviation, generated by the Medicaid recipient's county caseworker. Applies only to nursing residents.
cap	A finite limit on the number of certain services for which the department will pay for a given member per calendar year.
capitation	A prospective payment method that pays the provider of service a uniform amount for each person served usually on a monthly basis. Capitation is used in managed care alternatives such as HMOs.
CARF	Commission on Accreditation of Rehabilitation Facilities
carrier	An organization processing Medicare claims on behalf of the federal government.
carve out	A decision to purchase separately a service that is typically a part of an indemnity (a HMO plan). (For example, the behavioral health benefit might be carved out to a specialized vendor to supply these services as stand-alone.)
case management	A process whereby covered persons with specific health care needs are identified and a plan which efficiently uses health care resources is formulated and implemented to achieve the optimum outcome in the most cost-effective manner.
case manager	An experienced professional (for example, nurse, doctor or social worker) who works with clients, providers, and insurers to coordinate all necessary services to provide the client with a plan of medically necessary and appropriate health care.

Cash Control Number (CCN)	Financial control number assigned to uniquely identify all refunds or repayments prior to their setup within the cash control system. The batch range within the CCN identifies the type of refund or repayment.
cash control system	Process whereby the case unit creates and maintains the records for accounts receivable, recoupments, and payouts.
categorically needy	All individuals receiving financial assistance under the State's approved plan under Titles I, IV-A, X, XIV, and XVI of the Social Security Act or who are in need under the State's standards for financial eligibility in such plan.
category code	A designation indicating the type of benefits for which an IHCP member is eligible.
category of service	A designation of the nature of the service rendered (for example, hospital outpatient, pharmacy, physician).
CCF	Claim correction form. A CCF is generated by Indiana*AIM* and sent to the provider that submitted the claim. The CCF requests the provider to correct selected information and return the CCF with the additional or corrected information.
CCN	Cash control number. A financial control number assigned to identify individual transactions.
CCSW	Certified Clinical Social Worker.
CDC	Centers for Disease Control.
CDFC	County Division of Family and Children.
CDPW	County Department of Public Welfare, which is changed to the County Offices of the Division of Family and Children.
CDT	Current Dental Terminology.
CEO	Chief Executive Officer.
certification	A review of CMS of an operational MMIS in response to a state's request for 75 percent FFP, to ensure that all legal and operational requirements are met by the system; also, the ensuing certification resulting from a favorable review.
certification code	A code PCCM PMPs use to authorize PCCM members to seek services from speciality providers.
CFR	Code of Federal Regulations. Federal regulations that implement and define federal Medicaid law and regulations.
CHAMPUS	Civilian Health and Medical Plan for the Uniformed Services (CHAMPUS); health-care plan for active duty family members, military retirees and family members of military retirees, now known as TRICARE.
charge center	A provider accounting unit within an institution used to accumulate specific cost data related to medical and health services rendered (for example, laboratory tests, emergency room service, and so forth.).

Children's Special Health Care Services (CSHCS)	State program that provides assistance for children with chronic health problems who are not necessarily eligible for Medicaid.
CHIP	Children's Health Insurance Program.
CI	Continual improvement.
claim	A provider's request for reimbursement of IHCP-covered services. Claims are submitted to the State's claims processing contractor using standardized claim forms: CMS-1500, UB-92, ADA Dental Form, and State-approved pharmacy claim forms.
Claim Correction Form (CCF)	Automatically generated for certain claim errors and sent to providers with the weekly RA. Allows providers the opportunity to correct specified errors detected on the claim during the processing cycle.
claim transaction	Any one of the records processed through the Claims Processing Subsystem. Examples are: (1) Claims (2) Credits (3) Adjustments.
claim type	Three-digit numeric code that refers to the different billing forms used by the program.
claims history file	Computer file of all claims, including crossovers and all subsequent adjustments that have been adjudicated by the MMIS.
claims processing agency	Agency that performs the claims processing function for IHCP claims. The agency may be a department of the single state agency responsible for Title XIX or a contractor of the agency, such as a fiscal agent.
clean claim	Claim that can be processed without obtaining additional information from the provider or from a third party.
CLIA	Clinical Laboratory Improvement Amendments. A federally mandated set of certification criteria and a data collection monitoring system designed to ensure the proper certification of clinical laboratories.
client	A person enrolled in the IHCP and thus eligible to receive services funded through the IHCP.
Cm	Centimeter.
CMHC	Community Mental Health Center.
CMI	Case Mix Index.
CMN	Certificate of Medical Necessity.
CMS	Centers for Medicare and Medicaid Services.
CMS-1500	CMS-approved standardized claim form used to bill professional services. Formerly referred to as HCFA-1500.
COB	Coordination of benefits.

co-insurance	The portion of Medicare-determined allowed charge that a Medicare member is required to pay for a covered medical service after the deductible has been met. The co-insurance or a percentage amount is paid by IHCP if the member is eligible for Medicaid. See also *Cost Sharing*.
Commerce Clearing House Guide	A publication containing Medicaid and Medicare regulations.
Community Living Assistance and Support Services (CLASS)	A waiver of the Medicaid state plan granted under Section 1915(c) of the Social Security Act that allows Indiana to provide community-based services to people with development disabilities other than mental retardation as an alternative to ICF MR VIII institutional care. Administered by Department of Human Services (DHS). See also *ICF MR, 1915(c), Waiver*.
Computer-Output Microfilm (COM)	The product of a device that converts computer data directly to formatted microfilm images bypassing the normal print of output on paper.
concurrent care	Multiple services rendered to the same patient during the same time period.
consent to sterilization	Form used by IHCP members certifying that they give "informed consent" for sterilization to be performed (it must be signed at least 30 days prior to sterilization).
contract amendment	Any written alteration in the specifications, delivery point, rate of delivery, contract period, price, quantity, or other contract provisions of any existing contract, whether accomplished by unilateral action in accordance with a contract provision, or by mutual action of the parties to the contract. It includes bilateral actions, such as change orders, administrative changes, notices of termination, and notices of the exercise of a contract option.
Contractor	Offeror with whom the State successfully negotiated a contract pursuant to *IC 12-1-7-17*. **Auditing Contractor** – The entity under contract with the OMPP to conduct audits of long-term-care facilities or other functions and activities as designated by the OMPP. **Fiscal Agent Contractor** – The offeror(s) with whom the State successfully negotiated a contract to perform one or more business functions associated with claims processing and provider payment activities. **Rate-Setting Contractor** – Entities under contract with the OMPP to perform rate-setting activities for hospitals and long-term-care facilities.
conversion factor	Number that when multiplied by a particular procedure code's relative value units would yield a substitute prevailing charge that could be used when an actual prevailing charge does not exist.
copayment or copay	A cost-sharing arrangement that requires a covered person to pay a specified charge for a specified service, such as $10 for an office visit. The covered person is usually responsible for payment at the time the health care is rendered. See also *Cost Sharing*.

core contractor	The successful bidder on *Service Package #1: Claims Processing and Related Services*.
core services	Refers to *Service Package #1: Claims Processing and Related Services*.
COS	Category of Service.
cost settlement	Process by which claims payments to institutional providers are adjusted yearly to reflect actual costs incurred.
cost sharing	The generic term that includes co-payments, coinsurance, and deductibles. Co-payments are flat fees, typically modest, that insured persons must pay for a particular unit of service, such as an office visit, emergency room visit, or the filling of a drug prescription. Coinsurance is a percentage share of medical bills (for example, 20 percent) that an insured person must pay out-of-pocket. Deductibles are specified caps on out-of-pocket spending that an individual or a family must incur before insurance begins to make payments.
county office	County offices of Family and Children. Offices responsible for determining eligibility for Medicaid using the Indiana Client Eligibility System (ICES).
covered service	Mandatory medical services required by CMS and optional medical services approved by the State. Enrolled providers are reimbursed for these services provided to eligible IHCP members subject to the limitations of the *Indiana Administrative Code* (IAC).
CP	Clinical psychologist.
CPAS	Claims processing assessment system. An automated claims analysis tool used by the State for contractor quality control reviews.
CPM	Continuous Passive Motion.
CPS	Child Protective Services.
CPT	Current Procedural Terminology.
CPT Codes (Current Procedural Terminology)	Unique coding structure scheme of all medical procedures approved and published by the American Medical Association.
CPU	Central Processing Unit.
CQM	Continuous quality management.
credit	A claim transaction that has the effect of reversing a previously processed claim transaction.
CRF/DD	Community Residential Facility for the Developmentally Disabled.
Crippled Children's Program	Title V of the Social Security Act allowing states to locate and provide health services to crippled children or children suffering from conditions leading to crippling. Former term for CSHCS.

CRLD	Computer report to laser disk.
CRNA	Certified Registered Nurse Anesthetist.
crossover claim	A claim for services, rendered to a patient eligible for benefits under both Medicaid and Medicare Programs, Titles XVIII and XIX, potentially liable for payment of qualified medical services. (Medicare benefits must be processed prior to IHCP benefits).
CRT Terminal (Cathode-Ray Tube Terminal)	A type of input/output device that may be programmed for file access capabilities, data entry capabilities or both.
CSHCS	Children's Special Health Care Services. A State-funded program providing assistance to children with chronic health problems. CSHCS members do not have to be IHCP-eligible. If they are also eligible for the IHCP, children can be enrolled in both programs.
CSR	Customer Service Request.
CSW	Certified Social Worker
customer	Individuals or entities that receive services or interact with the contractor supporting the IHCP program, including State staff, members, and IHCP providers (managed care PMPs, managed care organizations, and waiver providers).
CVP	Central venous pressure.
D&E	Diagnostic and evaluation (in reference to services and providers).
DASS	Delivery and Support System.
data element	A specific unit of information having a unique meaning.
DC	Doctor of Chiropractic.
DD	Developmentally disabled or developmental disabilities.
DDARS	Division of Disability, Aging, and Rehabilitative Services.
DDE	Direct data entry.
DDS	Doctor of Dental Surgery.
deductible	Fixed amount that a Medicare member must pay for medical services before Medicare coverage begins. The deductible must be paid annually before Part B medical coverage begins; and it must be paid for each benefit period before Part A coverage begins.
DESI	Drug Efficacy Study and Implementation, drug determined to be less than effective (LTE); not covered by the IHCP.
designee	A duly authorized representative of a person holding a superior position.

detail	Information on a claim that denotes a specific procedure or category of certain services and the total charge billed for the procedure(s) involved. Also used to describe lines within a screen segment; for example, those listed to describe periods of eligibility.
development disability	Mental retardation of a related condition. A severe, chronic disability manifested during the developmental period that results in impaired intellectual functioning or deficiencies in essential skills. See also *Mental Retardation, Related Condition*.
DHHS	U.S. Department of Health and Human Services. DHHS is responsible for the administration of Medicaid at the federal level through CMS.
DHS	Department of Human Services.
diagnosis	The classification of a disease or condition. (1) The art of distinguishing one disease from another. (2) Determination of the nature of a cause of a disease. (3) A concise technical description of the cause, nature, or manifestations of a condition, situation, or problem. (4) A code for the above. See also *ICD-9-CM, DRG*.
digit	Any symbol expresses an idea or information, such as letters, numbers, and punctuation.
direct price	Price the pharmacist pays for a drug purchased from a drug manufacturer.
disallow	To determine that a billed service(s) is not covered by the IHCP and will not be paid.
disposition	Application of a cash refund to a previously finalized claim. Also used in processing claims to identify claim finalization—payment or denial.
DME	Durable medical equipment. Examples: wheelchairs, hospital beds, and other nondisposable, medically necessary equipment.
DMH	Division of Mental Health.
DMHA	Division of Mental Health and Addictions.
DO	Doctor of Osteopathy.
DOB	Date of birth.
DOS	Date of service; the specific day services were rendered.
down	Term used to describe the inactivity of the computer due to power shortages or equipment problems. Entries on a terminal are not accepted during down time.
DPOC	Data Processing Oversight Commission. Indiana state agency that oversees agency compliance with all State data processing statutes, policies, and procedures.
DPW	Department of Public Welfare, the previous name of the Family and Social Services Administration
DPW Form 8A	See *8A*.

DRG	Diagnosis-related grouping. Used as the basis for reimbursement of inpatient hospital services.
drug code	Code established to identify a particular drug covered by the IHCP.
Drug Efficacy Study and Implementation (DESI)	A drug determined to be less than effective (LTE) and not covered by the IHCP.
drug formulary	List of drugs covered by a State Medicaid Program, which includes the drug code, description, strength and manufacturer.
DSH	Disproportionate share hospital. A category defined by the State identifying hospitals that serve a disproportionately higher number of indigent patients.
DSM	Diagnostic and Statistical Manual of Mental Disorders; a revision series number is usually associated with the acronym.
DSS	Decision Support System. A data extraction tool used to evaluate IHCP data, trends, and so forth, for the purpose of making programmatic decisions.
dual eligible	A person enrolled in Medicare and Medicaid.
duplicate claim	A claim that is either totally or partially a duplicate of services previously paid.
DUR	Drug Utilization Review. A federally mandated, Medicaid-specific prospective and retrospective drug utilization review system and all related services, equipment, and activities necessary to meet all applicable federal DUR requirements.
E/M	Evaluation and Management.
EAC	Estimated acquisition cost of drugs. Federal pricing requirements for drugs.
ECC	Electronic claims capture. Refers to the direct transmission of electronic claims over phones lines to Indiana*AIM*. ECC uses point-of-sale devices and personal computers for eligibility verification, claims capture, application of Pro-DUR, prepayment editing, and response to and acceptance of claims submitted on-line. Also known as ECS and EMC.
ECF	Extended care facility; most commonly, long-term care (LTC); or nursing home (NH), or nursing facility (NF).
ECM	Electronic claims management; overall management of claim transmittal via electronic media; related to ECS, EMC, ECC, and paperless claims.
ECS	Electronic claims submission. Claims submitted in electronic format rather than paper. See ***ECC, EMC***.
EDI	Electronic data interchange.
EDP	Electronic data processing.
EDS	Electronic Data Systems Corporation, the IHCP claims processing and third party liability contractor.

EFT Electronic funds transfer. Paying providers for approved claims via electronic transfer of funds from the State directly to the provider's account.

EIP Early Intervention Program

eligibility file File containing individual records for all persons who are eligible or have been eligible for the IHCP.

eligible member Person certified by the State as eligible for medical assistance in accordance with the State Plan(s) under Title XIX of the Social Security Act, Title V of the Refugee Education Assistance Act, or State law.

eligible providers Person, organization, or institution approved by the Single State Agency as eligible for participation in the IHCP.

EMC Electronic media claims. Claims submitted in electronic format rather than paper. See ***ECC, ECS***.

EMS Emergency medical services.

EOB Explanation of benefits. An explanation of claim denial or reduced payment included on the provider's remittance advice.

EOMB Explanation of Medicare benefits. A form provided by Indiana*AIM* and sent to members. The EOMB details the payment or denial of claims submitted by providers for services provided to members. See also *MRN*.

EOP Explanation of payment, term previously used by the IHCP for the claim summary statement – currently know as a remittance advice (RA). Other insurers continue to use the term for claim statements to providers.

EPSDT Early and Periodic Screening, Diagnosis, and Treatment program. Known as HealthWatch in Indiana, EPSDT is a program for IHCP-eligible members younger than 21 years old offering free preventive health care services, such as: screenings, well-child visits, and immunizations. If medical problems are discovered, the member is referred for further treatment.

error code Code connected to a claim transaction indicating the nature of an error condition associated with that claim. An error code can become a rejection code if the error condition is such that the claim is rejected.

errors Claims that are suspended prior to adjudication. Several classifications of errors could exist; for example claims with data discrepancies or claims held up for investigation of possible third party liability. Claims placed on suspense for investigatory action can be excluded from classification as an error at the user's option during detail system design. See also *Rejected Claim*.

ESRD End Stage Renal Disease.

EST	Eastern Standard Time, which is also Indianapolis local time, is a constant in *the majority* of the state of Indiana. This means that from the last Sunday in April to the last Sunday in October Indianapolis is on the same time as the states observing Central Standard Time (CST), like Chicago. From the last Sunday in October to the last Sunday in April Indianapolis is on the same time as the states observing Eastern Standard Time (EST), like New York. This is because Indiana does not observe daylight savings time.
EVS	Eligibility Verification System. A system used by providers to verify member eligibility using a point-of-sale device, on-line PC access, or an automated voice-response system.
exclusions	Illnesses, injuries, or other conditions for which there are no benefits.
Exclusive Provider Organization (EPO)	Arrangement between a provider network and a health insurance carrier or self-insured employer that requires the beneficiary to use only designated providers or sacrifice reimbursement altogether. See also *Preferred Provider Organization.*
Explanation of benefits (EOB)	An explanation of claim denial or reduced payment included on the provider's RA.
Family Planning Service	Any medically approved diagnosis, treatment, counseling, drugs, supplies or devices prescribed or furnished by a physician to individuals of child-bearing age for purposes of enabling such individuals to determine the number and spacing of their children.
FAMIS	Family Assistance Management Information System.
FDB	First DataBank.
Fee-For-Service Reimbursement	The traditional health care payment system, under which physicians and other providers receive a payment for each unit of service they provide. See also *Indemnity Insurance*.
FEIN	Federal employer identification number. A number assigned to businesses by the federal government.
FFP	Federal financial participation. The federal government reimburses the State for a portion of the Medicaid administrative costs and expenditures for covered medical services.
FFS	Fee-for-service.
FID	Federal Investigation Database.
field audit	A provider's facilities, procedures, records and books are reviewed for conformance to IHCP standards. A field audit may be conducted regularly, routinely, or on a special basis to investigate suspected misutilization.
FIPS	Federal information processing standards.
Fiscal Agent Contractor	The offeror with whom the State successfully negotiated a contract to perform one or more business functions associated with claims processing and provider payment activities.

fiscal month	Monthly time interval in a fiscal year.
Fiscal Year	The designated annual reporting period for an entity: State of Indiana – July 1 through June 30 Federal – October 1 through September 30
FISS	Fiscal intermediary shared system.
flat rate	Reimbursement methodology in which all providers delivering the same service are paid at the same rate. Also known as a Uniform Rate.
FMAP	Federal Medical Assistance Percentage. The percentage of federal dollars available to a state to provide Medicaid services. FMAP is calculated annually based on a formula designed to provide a higher federal matching rate to states with lower per capita income.
Form 1261A	Division of Family and Children State Form 1261A, *Certification – Plan of Care for Inpatient Psychiatric Hospital Services Determination of Medicaid Eligibility*.
FPL	Federal poverty level. Income guidelines established annually by the federal government. Public assistance programs usually define income limits in relation to FPL.
FQHC	Federally Qualified Health Center. A center receiving a grant under the Public Health Services Act or entity receiving funds through a contract with a grantee. These include community health centers, migrant health centers, and health care for the homeless. FQHC services are mandated Medicaid services and may include comprehensive primary and preventive services, health education, and mental health services.
freedom of choice	A State must ensure that Medicaid beneficiaries are free to obtain services from any qualified provider. Exceptions are possible through waivers of Medicaid and special contract options.
front end	First process of claim cycle designed to create claim records, perform edits, and produce inventory reports.
front-end process	All claims system activity that occurs before auditing.
FSSA	Family and Social Services Administration. The Office of Medicaid Policy and Planning (OMPP) is a part of FSSA. FSSA is an umbrella agency responsible for administering most Indiana public assistance programs. However, the OMPP is designated as the single State agency responsible for administering the IHCP.
FTE	Full time employee.
FUL	Federal upper limit, the pricing structure associated with maximum allowable cost (MAC) pricing.
GCN*SEQND	Generic code sequence number classification system.
generic drug	A chemically equivalent copy designed from a brand name whose patent has expired and is typically less expensive.

Gm	Gram.
GPCI	Geographic practice cost index.
GPCPD	Governor's Planning Council for People with Disabilities.
GPI	Generic pricing indicator.
Group Model Health Maintenance Organization	A health care model involving contracts with physicians organized as a partnership, professional corporation, or other association. The health plan compensates the medical group for contracted services at a negotiated rate, and that group is responsible for compensating its physicians and contracting with hospitals for care of their patients.
group practice	A medical practice in which several physicians render and bill for services under a single billing provider number.
hard copy claim	A claim for services that was submitted on a paper claim form rather than via electronic means; also seen as "paper" and "manual".
HBP	Hospital-Based Physician. A physician who performs services in a hospital setting and has a financial arrangement to receive income from that hospital for the services performed.
HCBS	Home- and Community-Based Services waiver programs. A federal category of Medicaid services, established by Section 2176 of the Social Security Act. HCBS includes: adult day care, respite care, homemaker services, training in activities of daily living skills, and other services that are not normally covered by Medicaid. Services are provided to disabled and aged members to allow them to live in the community and avoid being placed in an institution.
HCE	Health Care Excel, Inc. The IHCP prior authorization, surveillance and utilization review and medical policy contractor
HCFA-1500	CMS-approved standardized claim form used to bill professional services. Now referred to as CMS-1500.
HCI	Hospital Care for the Indigent. A program that pays for emergency hospital care for needy persons who are not covered under any other medical assistance program.
HCPCS	Healthcare Common Procedure Coding System. A uniform health care procedural coding system approved for use by CMS. HCPCS includes all subsequent editions and revisions.
header	Identification and summary information at the head (top) of a claim form or report.
HealthWatch	Indiana's preventive care program for IHCP members younger than 21 years old. Also known as EPSDT.
HEDIS	Health Plan Employer Data and Information Set. A core set of performance measures developed for employers to use in assessing health plans.
help	An online computer function designed to assist users when encountering difficulties entering a screen.

HHA	Home Health Agency. An agency or organization approved as a home health agency under Medicare and designated by ISDH as a Title XIX home health agency.
HHPD	Hoosier Healthwise for Persons with Disabilities and Chronic Diseases, formerly referred to as MCPD. HHPD is one of three delivery systems in the Hoosier Healthwise managed care program. In HHPD, an MCO is reimbursed on a per capita basis per month to manage the member's health care. This delivery system serves people identified as disabled under the IHCP definition.
HHS	Health and Human Services. U.S. Department of Health and Human Services. Umbrella agency for the Office of Family Assistance, the CMS, the Office of Refugee Resettlement (ORR), and other federal agencies serving health and human service needs.
HIC	Health insurance carrier number.
HIC #	Health Insurance Carrier Number. Identification number for those patients with Medicare coverage. The HIC# is usually the patient's Social Security number and an alphabetic suffix that denotes different types of benefits.
HIO	Health insuring organization.
HIPAA	Health Insurance Portability and Accountability Act
HIPP	Health insurance premium payments.
HIV	Human Immunodeficiency Virus
HMO	Health maintenance organization.
HMO	Health maintenance organization. Organization that delivers and manages health services under a risk-based arrangement. The HMO usually receives a monthly premium or capitation payment for each person enrolled, which is based on a projection of what the typical patient will cost. If enrollees cost more, the HMO suffers losses. If the enrollees cost less, the HMO profits. This gives the HMO incentive to control costs. See also *Sections 1903(m) and 1915 (b), PHP, PPO, Primary Care Case Management.*
HMS	Health Management Services.
Home and Community Care for the Functionally Disabled	An optional state plan benefit that allows states to provide HCBS to functionally disabled individuals (In Indiana, this optional benefit is used by ISDH to provide personal care services to people who have income in excess of SSI limitations but who would be financially qualified in an institution.) Also known as the "Frail Elderly" provision, although Indiana can serve people of any age under this provision. See also *Section 1919, Primary Home Care.*
Home and Community-Based Services-Omnibus Budget Reconciliation Act (HCS-OBRA)	A waiver of the Medicaid state plan granted under Section *1915(c)(7)(b)* of the Social Security Act that allows Indiana to provide community-based services to certain people with developmental disabilities placed in nursing facilities but requiring specialized service according to the PASARR process. See also *Section 1915(c)(7)(b), PASARR, Waiver.*

Home Health Care Services	Visits ordered by a physician authorized by DHS and provided to homebound members by licensed registered and practical nurses and nurses aids from authorized home health care agencies. These services include medical supplies, appliances, and DME suitable for use in the home.
Hoosier Healthwise	Hoosier Healthwise is an IHCP managed care program that consists of two components including Primary Care Case Management (PCCM) and risk-based managed care (RBMC).
HOPA	Hospital outpatient area.
HPB	Health Professions Bureau.
HPSA	Health professional shortage area.
HPSB	Health Professions Service Bureau.
HRI	Health-related items.
HRR	High risk register (in relation to audiological screening).
HSA	Home service agency.
HSPP	Health services provider in psychology.
IAC	*Indiana Administrative Code – Indiana rules.* State government agency administrative procedures.
IC	Indiana Code – Indiana laws.
ICD-9-CM	International Classification of Diseases, 9th Revision, Clinical Modification. ICD-9-CM codes are standardized diagnosis codes used on claims submitted by providers.
ICES	Indiana Client Eligibility System. Caseworkers in the county offices of Family and Children use this system to help determine applicants' eligibility for medical assistance, food stamps, and Temporary Assistance for Needy Families (TANF).
ICF	Intermediate care facility. Institution providing health-related care and services to individuals who do not require the degree of care provided by a hospital or skilled nursing home, but who, because of their physical or mental condition, require services beyond the level of room and board.
ICF/MR	Intermediate care facility for the mentally retarded. An ICF/MR provides residential care treatment for IHCP-eligible, mentally retarded individuals.
ICHIA	Indiana Comprehensive Health Insurance Association, a health insuring organization for special situations.
ICLPPP	Indiana Childhood Lead Poisoning Prevention Program.
ICN	Internal control number. Number assigned to claims, attachments, or adjustments received in the fiscal agent contractor's mailroom.
ICU	Intensive care unit.

IDDARS	Indiana Division of Disability, Aging, and Rehabilitative Services.
IDEA	Individuals with Disabilities Education Act.
IDOA	Indiana Department of Administration. Conducts State financial operations including: purchasing, financial management, claims management, quality assurance, payroll for State staff, institutional finance, and general services such as leasing and human resources.
IEMS	Indiana Emergency Medical Service.
IEP	Individual Education Program (in relation to the First Steps Early Intervention System).
IFSP	Individual Family Service Plan (in relation to the First Steps Early Intervention System).
IFSSA	Indiana Family and Social Services Administration.
IHCP	Indiana Health Coverage Program.
IMCA	Indiana Motor Carrier Authority.
IMCS	Indiana Motor Carrier Services.
IMD	Institutions for mental disease.
IMF	Indiana Medical Foundation. Non-profit organization contracted by the DHS for the daily review and correction of abstracts submitted by all IHCP hospitals in Indiana.
IMFCU	Indiana Medicaid Fraud Control Unit.
IMRP	Indiana Medical Review Program. Program administered by the IMF to insure the medical necessity of hospitalization and surgery.
indemnity insurance	Insurance product in which beneficiaries are allowed total freedom to choose their health care providers. Those providers are reimbursed a set fee each time they deliver a service. See also *Fee-for-Service*.
Indiana Family and Social Service Administration (IFSSA)	The State agency responsible for the coordination and administration of social service programs in the state of Indiana. The OMPP, under Indiana Family and Social Security Administration (IFSSA), is the single State agency responsible for the administration of the IHCP.
Indiana State Department of Health (ISDH)	The State agency responsible for promotion of health; providing guidance on public health issues; ensuring the quality of health facilities and programs and the administration of certain health programs. The Bureau of Family Health Services is the bureau within the Indiana State Department of Health (ISDH) organization charged with the administration of the Children's Special Health Care Services Division (CSHCS) as well as the Maternal and Child Health Division (MCH) and the Division of Women, Infants, and Children (WIC).
Indiana*AIM*	Indiana Advanced Information Management system. The State's current Medicaid Management Information System (MMIS).

inquiry	Type of online screen programmed to display rather than enter information. Used to research information about members, providers, claims adjustments and cash transactions.
institution	An entity that provides medical care and services other than that of a professional person. A business other than a private doctor or a pharmacy.
intensive care	Level of care rendered by the attending physician to a critically ill patient requiring additional time and study beyond regular medical care.
interim	A billing that is only for a portion of the patient's continuous complete stay in an inpatient setting.
intermediary	Private insurance organizations under contract with the government handling Medicare claims from hospitals, skilled nursing facilities, and home health agencies.
IOC	Inspection of care. A core contract function reviewing the care of residents in psychiatric hospitals and ICFs/MR. The review process serves as a mechanism to ensure the health and welfare of institutionalized residents.
IPA	Individual Practice Associate. Model HMO. A health care model that contracts with an entity, which in turn contracts with physicians, to provide health care services in return for a negotiated fee. Physicians continue in their existing individual or group practices and are compensated on a per capita, fee schedule, or fee-for-service basis.
IPAS	Indiana Pre-Admission Screening.
IPP	Individualized Program Plan..
IRS	Identical, related, or similar drugs, in relation to less than effective (LTE) drugs.
ISBOH	Indiana State Board of Health; currently known as the Indiana State Department of Health.
ISDH	Indiana State Department of Health; previously known as Indiana State Board of Health.
ISETS	Indiana Support Enforcement Tracking System.
ISMA	Indiana State Medical Association.
itemization of charges	A breakdown of services rendered that allows each service to be coded.
ITF	Integrated test facility. A copy of the production version of Indiana*AIM* used for testing any maintenance and modifications before implementing changes in the production system.
JCL	Job control language.

Julian Date	A method of identifying days of the year by assigning numbers from 1 to 365 (or 366 on leap years) instead of by month, week, and day. For example, January 10 has a Julian date of 10 and December 31 has a Julian date of 365. This date format is easier and quicker for computer processing.
L	Liter.
LAN	Local area network.
LCL	Lower Control Limit (Pertaining to quality control charts).
LCN	Letter control number.
LCSW	Licensed Clinical Social Worker.
licensed practical nurse	LPN.
limited license practitioner	LLP.
line item	A single procedure rendered to a member. A claim is made up for one or more line items for the same member.
LLP	Limited license practitioner.
LMFT	Licensed Marriage and Family Therapist.
LMHC	Licensed Mental Health Counselor.
LOA	Leave of absence.
LOC	Level-of-care. Medical LOC review determinations are rendered by OMPP staff for purposes of determining nursing home reimbursement.
location	Location of the claim in the processing cycle such as paid, suspended, or denied.
lock-in	Restriction of a member to particular providers, determined as necessary by the State.
lock-out	Restriction of providers, for a time period, from participating in a portion or all of the IHCP due to exceeding standards defined by the department.
LOS	Length of stay.
LPN	Licensed Practical Nurse.
LSL	Lower specification limit, pertains to quality control charts.
LSW	Licensed Social Worker.
LTC	Long-term care. Used to describe facilities that supply long-term residential care to members.
LTE	Less than effective drugs.

M/M	Medicare/Medicaid.
MAC	Maximum allowable cost for drugs as specified by the federal government.
MAC	Monitored anesthesia care
managed care	System where the overall care of a patient is overseen by a single provider or organization. Many state Medicaid programs include managed care components as a method of ensuring quality in a cost efficient manner. See also *Section 1915(b), HMO, PPO, Primary Case Management.*
Managed Care PCCM	Members in the primary care case management delivery system are linked to a primary medical provider (PMP) that acts as a gatekeeper by providing and arranging for most of the members' medical care. The PMP receives an administrative fee per month for every member and is reimbursed on a fee-for-service basis.
Managed Care RBMC	In a risk-based managed care delivery system, the OMPP pays contracted managed care organizations (MCOs) a capitated monthly premium for each IHCP enrollee in the MCO's network. The care of members enrolled in the MCO is managed by the MCO through its network of PMPs, specialists and other providers of care, who contract directly with the MCO.
mandated or required services	Services a state is required to offer to categorically needy clients under a state Medicaid plan. (Medically needy clients may be offered a more restrictive service package.) Mandated services include the following: Hospital (IP & OP), lab/x-ray, nursing facility care (21 and over), home health care, family planning, physician, nurse midwives, dental (medical/surgical), rural health clinic, certain nurse practitioners, federally qualified health centers, renal dialysis services, HealthWatch/EPSDT (under age 21), medical transportation.
manual claim	Claim for services submitted on a paper claim form rather than via electronic means; also seen as *paper* and *hard copy*.
MARS	Management and Administrative Reporting Subsystem. A federally mandated comprehensive reporting module of Indiana*AIM* that includes data and reports as specified by federal requirements.
MCCA	Medicare Catastrophic Coverage Act of 1988.
MCO	Managed Care Organization. Entity that provides or contracts for managed care. MCOs include entities such as HMOs and Prepaid Health Plans (PHPs). See also *HMO, Prepaid Health Plan*.
MCPD	A pilot program that was available in Marion county from January 1997 through December 1999. It was a voluntary risk-based managed care program for IHCP enrollees that were considered disabled or chronically ill according to the State's established criteria.
MCS	Managed Care Solutions (now called Lifemark Corporation).
MD	Medical Doctor.
MDS	Minimum data set.

Medicaid	A joint federal-state entitlement program that pays for medical care on behalf of certain groups of low-income persons. The program was enacted in 1965 under Title XIX of the Social Security Act.
Medicaid certification	The determination of a member's entitlement to Medicaid benefits and notification of that eligibility to the agency responsible for Medicaid claims processing.
Medicaid Financial Report	State Form 7748, used for cost reporting.
Medicaid fiscal agent	Contractor that provides the full range of services supporting the business functions included in the core and non-core service packages.
Medicaid plan	See also *Medicaid State Plan, Single State Agency.*
Medicaid Select	A managed care program for the aged, blind and disabled population consisting of a Primary Care Case Management (PCCM) delivery system.
Medicaid State plan	See also *Single State Agency, Medicaid Plan.*
Medicaid-Medicare eligible	Member who is eligible for benefits under both Medicaid and Medicare. Members in this category are *bought-in* for Part B coverage of the Medicare Program by the Medicaid Program.
medical emergency	Defined by the American College of Emergency Physicians as a medical condition manifesting itself by symptoms of sufficient severity that the abscence of immediate medical attention could reasonable be expected to result in: (a) placing health in jeopardy; (b) serious impairment to bodily function; (c) serious dysfunction of any bodily organ or part; or (d) development or continuance of severe pain.
medical necessity	The evaluation of health care services to determine if they are: medically appropriate and necessary to meet basic health needs; consistent with the diagnosis or condition and rendered in a cost-effective manner; and consistent with national medical practice guidelines regarding type, frequency and duration of treatment.
medical policy	Portion of the claim processing system whereby claim information is compared to standards and policies set by the state for the IHCP.
medical policy contractor	Successful bidder on *Service Package #2: Medical Policy and Review Services.*
medical supplies	Supplies, appliances, and equipment.
medically needy	Individuals whose income and resources equal or exceed the levels for assistance established under a state or federal plan, but are insufficient to meet their costs of health and medical services.
Medicare	The federal medical assistance program described in Title XVIII of the Social Security Act for people over the age of 65, for persons eligible for Social Security disability payments and for certain workers or their dependents who require kidney dialysis or transplantation.

Medicare crossover	Process allowing for payment of Medicare deductibles and/or co-insurance by the Medicaid program.
Medicare deductibles and co-insurance	All charges classified as deductibles and/or coinsurance under Medicare Part A or Part B for services authorized by Medicare Part A or Part B.
member	A person who receives a IHCP service while eligible for the IHCP. People may be IHCP-eligible without being IHCP members. These individuals are called enrollees or members when in the Hoosier Healthwise Progam. See also *Client, Eligible Member*.
member relations	The activity within the single state agency that handles all relationships between the IHCP and individual member.
member restriction	A limitation or review status placed on a recipient that limits or controls access to the IHCP to a greater extent than for other nonrestricted members.
mental disease	Any condition classified as a neurosis, psychoneurosis, psychopathy, psychosis, or personality disorder.
mental illness	A single severe mental disorder, excluding mental retardation, or a combination of severe mental disorders as defined in the latest edition of the *American Psychiatric Association's Diagnostic and Statistical Manual of Mental Disorders*.
mental retardation	Significantly subaverage intellectual functioning existing concurrently with deficits in adaptive behavior and manifested during the developmental period.
menu	Online screen displaying a list of the available screens and codes needed to access the online system.
MEQC	Medicaid eligibility quality control.
MFCU	Medicaid Fraud Control Unit.
MHS	Managed Health Services.
MI	Mental illness.
MI/DD	Mental illness and developmental disability.
microfiche	Miniature copies of the RAs that can store approximately 200 pages of information on a plastic sheet about the size of an index card.
microfilm	Miniature copies of all claims received by Medicaid stored on film for permanent records-keeping and referral.
misutilization	Any usage of the IHCP by any of its providers or members not in conformance with both state and federal regulations, including both abuse and defects in level and quality of care.
Ml	Milliliter.
MLOS	Mean Length of Stay.

MMDDYY Format for a date to be reflected as month, day, and year such as 091599.

MMIS Medicaid Management Information System. Indiana's current MMIS is referred to as Indiana*AIM*.

MMRT Medicaid Medical Review Team.

MOC Memorandum of Collaboration; a Hoosier Healthwise document that provides a formal description of the terms of collaboration between the primary medical provider (PMP) and the preventive health care service provider (PHCSP). It also serves as a tool for delineating responsibilities for referrals on a continuous basis. MOCs must be signed by both parties and are subject to OMPP approval.

MOC Memoranda of Collaboration. For example, a Hoosier Healthwise document that provides a formal description of the terms of collaboration between a PMP and PHCSP, and serves as a tool for delineating responsibilities for referrals on a continuous basis. MOCs must be signed by both parties and are subject to OMPP approval.

module A group of data processing and/or manual processes that work in conjunction with each other to accomplish a specific function.

MR/DD Mental retardation and developmentally disabled.

MRN Medicare Remittance Notice. A form provided by Indiana*AIM* and sent to members. The MRN details the payment or denial of claims submitted by providers for services provided to members.

MRO Medicaid Rehabilitation Option. Special program restricted to community mental health centers for persons who are seriously mentally ill or seriously emotionally disturbed.

MRT Medical Review Team, unit which makes decision regarding Disability Determination.

MS Mail stop.

MSN Master of Science in Nursing.

MSS Master of Social Sciences.

MSW Master of Social Work.

MWU Medicaid Waiver Unit, the IDDARS unit which manages the HCBS Waiver Programs.

NAS Non-ambulatory service.

NASW National Association of Social Workers.

NCPDP National Council for Prescription Drug Programs.

NDC National Drug Code. A generally accepted system for the identification of prescription and non-prescription drugs available in the United States. NDC includes all subsequent editions, revisions, additions, and periodic updates.

NDDF	National Drug Data File.
NEC	Not elsewhere classified.
NECS	National Electronic Claims Submission is the proprietary software developed by EDS. NECS is installed on a provider's PCs and used to submit claims electronically. The software allows providers access to on-line, real-time eligibility information.
Network Model HMO	An HMO type in which the HMO contracts with more than one physician group, and may contract with single- and multi-specialty groups. The physician works out of his or her own office. The physician may share in utilization savings, but does not necessarily provide care exclusively for HMO members.
NF	Nursing facility; also seen as ECF, NH, and LTC.
NH	Nursing home; also seen as ECF, NF, and LTC.
NIH	National Institutes of Health.
NOC	Not otherwise classified.
non-core contractors	Refers to the Medical Policy Contractor and the TPL/Drug Rebate Contractor.
non-core services	Refers to *Service Packages #2 and #3*.
NOOH	Notice of Opportunity for Hearing. Notification that a drug product is the subject of a notice of opportunity for hearing issued under Section 505(e) of the Federal Food, Drug, and Cosmetic Act and published in the *Federal Register* on a proposed order of FDA to withdraw its approval for the drug product because it has determined that the product is less than effective for all its labeled indications.
NPIN	National provider identification number.
nursing facilities	Facilities licensed by and approved by the state in which eligible individuals receive nursing care and appropriate rehabilitative and restorative services under the Title XIX (Medicaid) Long Term Care Program. See also *Long Term Care, TILE.*
nursing facility waiver (NF waiver)	A waiver of the Medicaid's state plan granted under Section 1915(c) of the Social Security Act that allows Indiana to provide community-based services to adults as an alternative to nursing facility care. See also *Nursing Facilities, 1915(c), Waiver*.
OASDI	Old Age, Survivors and Disability Insurance. See also *Title II Benefits (Social Security or OASDI)*.
OB/GYN	Obstetrician/Gynecologist.
OBRA	Omnibus Budget Reconciliation Act.
OBRA-90	Omnibus Budget Reconciliation Act of 1990.
OCR	Optical Character Recognition Equipment. A device that reads letters or numbers from a page and converts them to computerized data, bypassing data entry.

OD	Doctor of Optometry.
OFC	Office of Family and Children.
OIG	Office of the Inspector General.
OMNI	A point-of-sale device used by providers to scan member ID cards to determine eligibility.
OMPP	Office of Medicaid Policy and Planning.
optional services or benefits	More than 30 different services that a state can elect to cover under a state Medicaid plan. Examples include personal care, rehabilitative services, prescribed drugs, therapies, diagnostic services, ICF-MR, targeted case managed, and so forth.
OTC	Over the counter, in reference to drugs.
other insurance	Any health insurance benefits that a patient might possess in addition to Medicaid or Medicare.
other processing agency	Any organization or agency that performs IHCP functions under the direction of the single state agency. The single state agency may perform all IHCP functions itself or it may delegate certain functions to other processing agencies.
outcome measures	Assessments that gauge the effect or results of treatment for a particular disease or condition. Outcome measures include the patient's perception of restoration of function, quality of life and functional status, as well as objective measures of mortality, morbidity, and health status.
outcomes	Results achieved through a given health care service, prescription drug use, or medical procedure.
outcomes management	Systematically improving health care results, typically by modifying practices in response to data gleaned through outcomes measurement, then remeasuring and remodifying, often in a formal program of continuous quality improvement.
outcomes research	Studies aimed at measuring effect of a given product, procedure, or medical technology on health or costs.
outlier	An additional payment made to hospitals for certain clients under age 21 for exceptionally long or expensive hospital stays.
out-of-state	Billing for a IHCP member from a facility or physician outside Indiana or from a military facility.
outpatient services	Hospital services and supplies furnished in the hospital outpatient department or emergency room and billed by a hospital in connection with the care of a patient who is not a registered bed patient.
overpayment	An amount included in a payment to a provider for services provided to a IHCP member resulting from the failure of the contractor to use available information or to process correctly.

override	Forced bypassing of a claim due to error (or suspected error), edit, or audit failure during claims processing. Exempted from payment pending subsequent investigation not to be in error.
overutilization	Use of health or medical services beyond what is considered normal.
PA	Prior authorization. Some designated IHCP services require providers to request approval of certain types or amounts of services from the State before providing those services. The Medical Services Contractor and/or State medical consultants review PAs for medical necessity, reasonableness, and other criteria.
paid amount	Net amount of money allowed by the IHCP.
paid claim	Claim that has had some dollar amount paid to the provider, but the amount may be less than the amount billed by the provider.
paid claims history file	History of all claims received by IHCP that have been handled by the computer processing system through a terminal point. Besides keeping history information on paid claims, this file also has records of claims that were denied.
paper claim	A claim for services that was submitted on a paper claim form rather than via electronic means; also seen as *hard copy* and *manual*.
paperless claims	Claims sent by electronic means; equivalent to EMC, ECS, ECC, and similar terms denoting claim transmittal via electronic media.
parameter	Factor that determines a range of variations.
Part A	Medicare hospital insurance that helps pay for medically necessary inpatient hospital care, and after a hospital stay, for inpatient care in a skilled nursing facility, for home care by a home health agency or hospice care by a licensed and certified hospice agency. See also *Medicare, Beneficiary*.
Part B	Medicare medical insurance that helps pay for medically necessary physician services, outpatient hospital services, outpatient physical therapy, and speech pathology services, and a number of other medical services and supplies that are not covered by the hospital insurance. Part B will pay for certain inpatient services if the beneficiary does not have Part A. See also *Medicare, SMIB, Buy-In*.
participant	One who participates in the IHCP as either a provider or a member of services.
participating members	Individuals who receive Title XIX services during a specified period of time.
participating providers	Providers who furnish Title XIX services during a specified period of time.
participation agreement	A contract between a provider of medical service and the state that specifies the conditions and the services the facility must provide to serve IHCP members and receive reimbursement for those services.
PAS	Pre-admission screening. A nursing home and community-based services program implemented on January 1, 1987, that is designed to screen a member's potential for remaining in the community and receiving community-based services as an alternative to nursing home placement.

PAS Form 4B	Pre-Admission Screening Notice of Assessment Determination form.
PASRR	Pre-Admission Screening and Resident Review. A set of federally required long-term care resident screening and evaluation services, payable by the Medicaid program, and authorized by the Omnibus Budget and Reconciliation Act of 1987.
payouts	Generate payments to providers for monies owed to them that are not claim related. Payouts are done as the result of cost settlements or to return excess refunds to the provider.
PC	Personal computer.
PCA	Physician's Corporation of America. An HMO providing health benefits to Medicaid clients.
PCCM	Members in the Primary Care Case Management delivery system are linked to a primary medical provider (PMP) that acts as a gatekeeper by providing and arranging for most of the members' medical care. The PMP receives an administrative fee per month for every member and is reimbursed on a fee-for-service basis.
PCN	Primary care network.
PCP	Primary Care Provider.
PCP	Primary care physician. A physician the majority of whose practice is devoted to internal medicine, family/general practice, and pediatrics. An obstetrician/gynecologist may be considered a primary care physician.
PDD	Professional data dimensions.
PDR	Provider Detail Report/Provider Desk Review.
peer	A person or committee in the same profession as the provider whose claim is being reviewed.
peer review	An activity by a group or groups of practitioners or other providers, by which the practices of their peers are reviewed for conformance to generally-accepted standards.
PEN	Parenteral and enteral nutrition .
pending (claim)	Action of postponing adjudication of a claim until a later processing cycle.
per diem	Daily rate charged by institutional providers.
performing provider	Party who actually performs the service/provides treatment.
PERS	Personal emergency response system, an electronic device which enables the consumer to secure help in an emergency.

personal care	Optional Medicaid benefit that allows a state to provide attendant services to assist functionally impaired individuals in performing the activities of daily living (for example, bathing, dressing, feeding, grooming). Indiana provides Primary Home Care Services under this option. See also *Primary Home Care*.
PET	Positron Emission Tomography.
PGA	Peer group average.
PHC	Primary home care. IHCP-funded community care that provides personal care services to over 40,000 aged or disabled people in Indiana. PHC is provided as an optional state plan benefit. See also *Personal Care*.
PHCSP	Preventive health care services provider; a provider of well-child care, pre-natal care services, or care coordination services.
PHO	Physician hospital organization.
PHP	Prepaid health plan. A partially capitated managed care arrangement in which the managed care company is at risk for certain outpatient services. See also *VISTA.*
physician hospital organization	An organization whose board is composed of physicians, but with a hospital member, formed for the purpose of negotiating contracts with insurance carriers and self-insured employers for the provision of health care services to enrollees by the hospital and participating members of the hospital's medical staff.
PKU	Phenylketonuria.
Plan of Care	A formal plan developed to address the specific needs of an individual. It links clients with needed services.
PM/PM	Per member per month. Unit of measure related to each member for each month the member was enrolled in a managed care plan. The calculation is as follows: # of units/member months (MM).
PMF	Provider master file.
PMP	Primary medical provider. A physician who approves and manages the care and medical services provided to IHCP members assigned to the PMP's care.
pool (risk pool)	A defined account (for example, defined by size, geographic location, claim dollars that exceed **x** level per individual, and so forth) to which revenue and expenses are posted. A risk pool attempts to define expected claim liabilities of a given defined account as well as required funding to support the claim liability.
POS	Place of service or point of sale, depending on the context.
PPO	Preferred provider organization. An arrangement between a provider network and a health insurance carrier or a self-insured employer. Providers generally accept payments less than traditional fee-for-service payments in return for a potentially greater share of the patient market. PPO enrollees are not required to use the preferred providers, but are given strong financial incentives to do so, such as reduced coinsurance and deductibles. Providers do not accept financial risk for the management of care. See also *Exclusive Provider Organization (EPO).*

PR	Provider relations.
practitioner	An individual provider. One who practices a health or medical service profession.
Premium	Due from member in order to be eligible for Package C.
pre-payment review	Provider claims suspended temporarily for dispositioning and manual review by the HCE SUR Unit.
prescription medication	Drug approved by the FDA that can, under federal or state law, be dispensed only pursuant to a prescription order from a duly licensed physician.
preventive care	Comprehensive care emphasizing priorities for prevention, early detection and early treatment of conditions, generally including routine physical examination, immunization, and well person care.
pricing	Determination of the IHCP allowable.
primary care	Basic or general health care traditionally provided by family practice, pediatrics, and internal medicine.
prime contractor	Contractor who contracts directly with the State for performance of the work specified.
print-out	Reports and information printed by the computer on data correlated in the computer's memory.
prior authorization	An authorization from the IHCP for the delivery of certain services. It must be obtained prior to the service for benefits to be provided within a certain time period, except in certain allowed instances. Examples of such services are abortions, goal-directed therapy, and EPSDT dental services.
Prior Authorization or Prior Review and Approval	The procedure for the office's prior review and authorization, modification, or denial of payment for covered medical services and supplies within IHCP allowable charges. It is based on medical reasonableness, necessity, and other criteria as described in the *IAC Covered Services Rule* and *Medical Policy Rule* found in the *Appendix* to this manual.
private trust	Trust fund available to pay medical expenses.
PRO	Peer review organization.
procedure	Specific, singular medical service performed for the express purpose of identification or treatment of the patient's condition.
procedure code	A specific identification of a specific service using the appropriate series of coding systems such as the CDT, CPT, HCPCS, or ICD-9-CM.
processed claim	Claim where a determination of payment, nonpayment, or pending has been made. See also *Adjudicated Claim*.
Pro-DUR	Prospective Drug Utilization Review. The federally mandated, Medicaid-specific prospective drug utilization review system and all related services and activities necessary to meet all federal Pro-DUR requirements and all DUR requirements.

profile	Total view of an individual provider's charges or a total view of services rendered to a member.
program director	Person at the contractor's local office who is responsible for overseeing the administration, management, and daily operation of the MMIS contract.
prosthetic devices	Devices that replace all or part of an internal body organ or replace all or part of the function of a permanently inoperative or malfunctioning body organ or limb.
provider	Person, group, agency, or other legal entity that is enrolled as a provider of services and provides a covered IHCP service to an IHCP member.
Provider Agreement	A contract between a provider and the OMPP setting out the terms and conditions of a provider's participation in the IHCP. It must be signed by the provider prior to any reimbursement for providing covered services to members.
provider enrollment application	Required document for all providers who provide services to IHCP members.
provider manual	Primary source document for IHCP providers.
provider networks	Organizations of health care providers that service managed care plans. Network providers are selected with the expectation they deliver care inexpensively, and enrollees are channeled to network providers to control costs.
provider number	Unique individual or group number assigned to practitioners participating in the IHCP.
provider relations	Function or activity within that handles all relationships with providers of health care services.
provider type	Classification assigned to a provider such as hospital, doctor or dentist.
PSRO	Professional standards review organization.
purged	Claims are removed from history files according to specific criteria after 36 months from the claim's last financial date. Claims data is online for up to 36 months.
QA	Quality assurance.
QARI	Quality Assurance Reform Initiative. Guidelines established by the federal government for quality assurance in Medicaid managed care plans.
QDWI	Qualified disabled working individual. A federal category of Medicaid eligibility for disabled individuals whose incomes are less than 200 percent of the federal poverty level. Medicaid benefits cover payment of the Medicare Part A premium only.
QM	Quality management.

QMB	Qualified Medicare beneficiary. A federal category of Medicaid eligibility for aged, blind, or disabled individuals entitled to Medicare Part A whose incomes are less than 100 percent of the federal poverty level and assets less than twice the SSI asset limit. Medicaid benefits include payment of Medicare premiums, coinsurance, and deductibles only.
QMHP	Qualified mental health professional.
QMRP	Qualified mental retardation professional.
quality improvement	A continuous process that identifies problems in health care delivery, tests solutions to those problems, and constantly monitors the solutions for improvement.
QUCR	Quarterly Utilization Control Reports.
query	An inquiry for specific information not supplied on standardized reports.
RA	Remittance advice. A summary of payments produced by Indiana*AIM* explaining the provider reimbursement. RAs are sent to providers along with checks or EFT records.
Rate-Setting Contractor	An entity under contract with the OMPP to perform rate-setting activities.
RBA	Room and Board Assistance.
RBMC	In a risk-based managed care delivery system, the OMPP pays contracted managed care organizations (MCOs) a capitated monthly premium for each IHCP enrollee in the MCO's network. The care of members enrolled in the MCO is managed by the MCO through its network of PMPs, specialists and other providers of care, who contract directly with the MCO.
RBRVS	Resource-based relative value scale. A reimbursement method used to calculate payment for physician, dentists, and other practitioners.
reasonable charge	Charge for health care services rendered that is consistent with efficiency, economy, and quality of the care provided, as determined by the OMPP.
reasonable cost	All costs found necessary in the efficient delivery of needed health services. Reasonable cost is the normal payment method for Medicare Part A.
recidivism	The frequency of the same patient returning to a provider with the same presenting problems. Usually refers to inpatient hospital services.
Red Book	Listing of the average wholesale drug prices.
referring provider	Provider who refers a member to another provider for treatment service.
regulation	Federal or state agency rule of general applicability designed and adopted to implement or interpret law, policy, or procedure.
reimbursement	Payment made to a provider, pursuant to Federal and State law, as compensation for providing covered services to members.

reinsurance	Insurance purchased by an HMO, insurance company, or self-funded employer from another insurance company to protect itself against all or part of the losses that may be incurred in the process of honoring the claims of its participating providers, policy holders, or employees and covered dependents. See also *Stop-Loss Insurance*.
rejected claim	Claim determined to be ineligible for payment to the provider, contains errors, such as claims for noncovered services, ineligible provider or patient, duplicate claims, or missing provider signature. Returned to the responsible provider for correction and resubmission prior to data entry into the system.
related condition	Disability other than mental retardation which manifests during the developmental period (before age 22) and results in substantial functional limitations in three of six major life activities (for example, self-care, expressive/receptive language, learning, mobility, self-direction, and capacity for independent living). These disabilities, which may include cerebral palsy, epilepsy, spina bifida, head injuries, and a host of other diagnoses, are said to be related to mental retardation in their effect upon the individual's functioning.
remittance advice (RA)	Comprehensive billing information concerning the member disposition of a provider's submitted IHCP claims.
Remittance and Status Report (R/A)	A computer report generated weekly to a provider to inform the provider about the status of finalized and pending claims. The R/A includes EOB codes that describe the reasons for claim cutbacks, and denials. The provider receives a check enclosed in the R/A when claims are paid.
rendering provider	A provider employed by a clinic or physician group that provides service as an employee. The employee is compensated by the group and therefore does not bill directly.
rep	Provider relations representative.
repayment receivables	Transaction established in the Cash Control System when a provider has received payment to which he was not entitled.
report item	Any unit of information or data appearing on an output report.
required field	Screen field that must be filled to display or update desired information.
resolution	Step taken to correct an action that caused a claim to suspend from the system.
resolutions	The area within the processing department responsible for edit and audit correction.
Retro-DUR	Retrospective Drug Utilization Review.
RFI	Request for Information.
RFP	Request for Proposals.
RHC	Rural health clinic
RID	Recipient Identification (ID) number; the unique number assigned to a member who is eligible for IHCP services.

risk contract	An agreement with an MCO to furnish services for enrollees for a determined, fixed payment. The MCO is then liable for services regardless of their extent, expense or degree. See also *MCO, Pool, Risk Pool.*
RN	Registered Nurse.
RNC	Registered Nurse Clinician.
route	Transfer of a claim to a certain area for special handling and review.
routine	A condition that can wait for a scheduled appointment.
RPT	Registered physical therapist.
RPTS	Research Project Tracking System.
RR	Resident review.
RUG	Resource Utilization Group.
rural health clinic	Any agency or organization that is a rural health clinic certified and participating under Title XVIII of the Social Security Act and has been designated by DHS as a Title XIX rural health clinic.
RVS	Relative value study. A procedure coding structure for all medical procedures, based on the most common procedure used, that assigns relative value units to medical procedures according to the degree of difficulty.
RVU	Relative value unit.
SA/DE	State Authorization/Data Entry.
SBOH	State Board of Health; previous term for the State Department of Health.
SCP	Specialty care physicians.
screening	The use of quick, simple procedures carried out among large groups of people to sort out apparently well persons from those who have a disease or abnormality and to identify those in need of more definitive examination or treatment.
SD	Standard deviation.
SDA	Standard dollar amount.
SDX	State Data Exchange System. The Social Security Administration's method of transferring SSA entitlement information to the State.
SED	Seriously emotionally disturbed.
SEH	Seriously emotionally handicapped.
selective contracting	Option under Section *1915(b)* of the Social Security Act that allows a state to develop a competitive contracting system for services such as inpatient hospital care.
SEPG	Software Engineering Process Group.

service date	Actual date on which a service(s) was rendered to a particular member by a particular provider.
service limits	Maximum number of service units to which a member is entitled, as established by the IHCP for a particular category of service. For example, the number of inpatient hospital days covered by the IHCP might be limited to no more than 30 days.
SG	Steering group.
shadow claims	Reports of individual patient encounters with a managed care organization's (MCO's) health care delivery system. Although MCOs are reimbursed on a per capita basis, these claims from MCOs contain fee-for-service equivalent detail regarding procedures, diagnoses, place of service, billed amounts, and the rendering or billing providers.
SI/IS	Severity of illness/intensity of services.
SIPOC	System map outlining suppliers, inputs, processes/functions, outputs, and customers.
SLMB	Specified low-income Medicare beneficiary. A federal category defining Medicaid eligibility for aged, blind, or disabled individuals with incomes between 100 percent and 120 percent of the federal poverty level and assets less than twice the SSI asset level. Medicaid benefits include payment of the Medicare Part B premium only.
SMI	Severely mentally ill.
SMI	Supplemental medical insurance, Part B of Medicare.
SNF	Skilled nursing facility.
SOBRA	Sixth Omnibus Budget Reconciliation Act.
SOBRA	Omnibus Budget Reconciliation Act of 1986.
SPC	Statistical process control.
special vendors	Provide support to IHCP business functions but the vendors are not currently Medicaid fiscal agents.
specialty	Specialized practice area of a provider.
specialty certification	Certification or approval by professional academy, association, or society that designates this provider has demonstrated a given level of training or competence and is a fellow or specialist.
specialty vendors	Provide support to IHCP business functions but the vendors are not currently IHCP fiscal agents.
Spend-down	Process whereby IHCP eligibility may be established if an individual's income is more than that allowed under the State's income standards and incurred medical expenses are at least equal to the difference between the income and the medically needy income standard.

SPMI	Severe and persistent mental illness.
SPR	System performance review.
SSA	Social Security Administration of the federal government.
SSCN	Social security claim number. Account number used by SSA to identify the individual on whose earnings SSA benefits are being paid. It is a social security account number followed by a suffix, sometimes as many as three characters, designating the type of beneficiary (for example, wife, widow, child, and so forth). The SSCN is the number that must be used in the Buy-In program. A beneficiary can have his own SSN but be receiving benefits under a different claim number.
SSI	Supplementary Security Income. A federal supplemental security program providing cash assistance to low-income aged, blind, and disabled persons.
SSN	Social Security Account Number. The number used by SSA throughout a wage earner's lifetime to identify his or her earnings under the Social Security Program. This account number consists of nine figures generally divided into three hyphenated sets, such as 000-00-0000. The account number is commonly known as the Social Security Number. The number is not to be confused with Social Security Claim Number.
SSP	State Supplement Program. State-funded program providing cash asssistance that supplements the income of those aged, blind, and disabled individuals who are receiving SSI (or who, except for income or certain other criteria, would be eligible for SSI).
SSRI	Selective Serotonin Re-uptake Inhibitor.
Staff Model HMO	Health care model that employs physicians to provide health care to its members. All premiums and other revenues accrue to the HMO, which compensates physicians by salary and incentive programs.
standard business	Health care business within the private sector of the industry, such as Blue Cross and Blue Shield.
State	Spelled as shown, State refers to the state of Indiana and any of its departments or agencies.
State fiscal year	A 12-month period beginning July 1 and ending June 30.
State Form 11971	See *8A.*
State Form 7748	Medicaid Financial Report, used for cost reporting.
State Medicaid Office	Office of Medicaid Policy and Planning, within the Family and Social Services Administration, responsible for administering the IHCP in Indiana.
State Plan	The medical assistance plan of Indiana as approved by the Secretary of Health, Education and Welfare in accordance with provisions of Title XIX of the Social Security Act, as amended.
status	Condition of a claim at a given time; such as paid, pended, denied, and so forth.

stop-loss insurance Insurance coverage taken out by a health plan or self-funded employer to provide protection from losses resulting from claims greater than a specific dollar amount per covered person per year (calendar year or illness-to-illness). Types of stop-loss insurance: (1) Specific or individual-reimbursement is given for claims on any covered individual which exceed a predetermined deductible, such as $25,000 or $50,000; (2) Aggregate-reimbursement is given for claims which in total exceed a predetermined level, such as 125 percent of the amount expected in an average year. See also *Reinsurance*.

subcontractor Any person or firm undertaking a part of the work defined under the terms of a contract, by virtue of an agreement with the prime contractor. Before the subcontractor begins, the prime contractor must receive the written consent and approval of the State.

submission The act of a provider sending billings to EDS for payment.

subsystem A Medicaid term that refers to one of the following (I)HIS processing components: member's subsystem, provider subsystem, claims processing subsystem, reference file subsystem, surveillance and utilization review subsystem, and management and administrative reporting subsystem.

SUR Surveillance and Utilization Review. Refers to system functions and activities mandated by the Centers for Medicare and Medicaid Services (CMS) that are necessary to maintain complete and continuous compliance with CMS regulatory requirements for SUR including the following SPR requirements:

1. Statistical analysis
2. Exception processing
3. Provider and member profiles
4. Retrospective detection of claims processing edit and audit failures and errors
5. Retrospective detection of payments and/or utilization inconsistent with State or federal program policies and/or medical necessity standards
6. Retrospective detection of fraud and abuse by providers or members
7. Sophisticated data and claim analysis including sampling and reporting
8. General access and processing features
9. General reports and output

Survey Agency The ISDH is the designated survey agency responsible for surveying, monitoring, reviewing, and certifying institutional providers of service who request or agree to participate in the IHCP. The ISDH also certifies several other provider types. These types are discussed under the section titled; *State, County Contractor Responsibilities* included in this chapter.

suspended transaction A suspended transaction requires further action before it becomes a paid or denied transaction, usually because of the presence of error(s).

suspense file Computer file where various transactions are placed that cannot be processed completely, usually because of the presence of an error condition(s).

systems analyst or engineer	Responsible for performing the following activities: 10. Detailed system and program design 11. System and program development 12. Maintenance and modification analysis and resolution 13. User needs analysis 14. User training support 15. Development of personal IHCP knowledge
TANF	Temporary Assistance for Needy Families. A replacement program for Aid to Families with Dependent Children.
TBI	Traumatic brain injury.
TEFRA	Tax Equity and Fiscal Responsibility Act of 1982. The federal law which created the current risk and cost contract provisions under which health plans contract with CMS and which define the primary and secondary coverage responsibilities of the Medicare program.
TEFRA 134(a)	Provision of the Tax Equity and Fiscal Responsibility Act of 1982 that allows states to extend Medicaid coverage to certain disabled children.
therapeutic classification	Code assigned to a group of drugs that possess similar therapeutic qualities.
third party	An individual, institution, corporation, or public or private agency that is liable to pay all or part of the medical cost of injury, disease, or disability of an applicant for, or member of, medical assistance under Title XIX.
third-party resource	A resource available, other than from the department, to an eligible member for payment of medical bills. Includes, but is not limited to, health insurance, workmen's compensation, liability, and so forth.
Title I	The Old Age Assistance Program that was replaced by the Supplemental Security Income program (SSI).
Title II	Old Age, Survivors and Disability Insurance Benefits (Social Security or OASDI).
Title IV-A	AFDC, WIN Social Services.
Title IV-B	Child Welfare.
Title IV-D	Child Support.
Title IV-E	Foster Care and Adoption.
Title IV-F	Job Opportunities and Basic Skills Training.
Title V	Maternal and Child Health Services.
Title X	Aid to the Blind program (AB) replaced by the SSI.
Title XIV	Permanently and Totally Disabled program (PTD) replaced by the SSI.

Title XIX	Provisions of Title 42, United States code Annotated Section 1396-1396g, including any amendments thereto.
Title XIX Hospital	Hospital participating as a hospital under Medicare, that has in effect a utilization review plan (approved by DHS) applicable to all recipients to whom it renders services or supplies, and which has been designated by DHS as a Title XIX hospital; or a hospital not meeting all of the requirements of Subsection A.5.1.0.0.0 of the RFP but that renders services or supplies for which benefits are provided under Section 1814 (d) of Medicare or would have been provided under such section had the recipients to whom the services or supplies were rendered been eligible and enrolled under part A of Medicare, to the extent of such services and supplies only, and then only if such hospital has been approved by DHS to provide emergency hospital services and agrees that the reasonable cost of such services or supplies, as defined in Section 1901 (a) (13) of title XIX, shall be such hospital's total charge for such services and supplies.
Title XV	ISSI.
Title XVI	The SSI.
Title XVIII	The Medicare Health Insurance program covering hospitalization (Part A) and medical insurance (Part B); the provisions of Title 42, United States Code Annotated, Section 1395, including any amendments thereto.
TPL	Third Party Liability. A client's medical payment resources, other than Medicaid, available for paying medical claims. These resources generally consist of public and private insurance carriers.
TPL/Drug Rebate Services	Refers to *Service Package #3: Third-Party Liability and Drug Rebate Services*.
TPN	Total Parenteral Nutrition.
TQM	Total Quality Management.
trend	Measure of the rate at which the magnitude of a particular item of date is changing.
TRICARE	Formerly known as the Civilian Health and Medical Plan for the Uniformed Services (CHAMPUS); health-care plan for active duty family members, military retirees, and family members of military retirees.
UB-92	Standard claim form used to bill hospital inpatient and outpatient, nursing facility, intermediate care facility for the mentally retarded (ICF/MR), and hospice services.
UCC	Usual and customary charge.
UCL	Upper control limit, pertaining to quality control charts.
UCR	Usual, customary, and reasonable charge by providers to their most frequently billed nongovernmental third party payer.
UM	Utilization management.
unit of service	Measurement divisions for a particular service, such as one hour, one-quarter hour, an assessment, a day, and so forth.

UPC	Universal product code. Codes contained on the first data bank tape update or applied to products such as drugs and other pharmaceutical products.
UPIN	Universal provider identification number.
UR	Utilization Review. A formal assessment of the medical necessity, efficiency, or appropriateness of health care services and treatment plans on a prospective, concurrent or retrospective basis.
urgent	Defined as a condition not likely to cause death or lasting harm, but for which treatment should not wait for the next day or a scheduled appointment.
user	Data processing system customer or client.
USL	Upper specification limits, pertaining to quality control charts.
USPHS	United States Public Health Service.
utilization	The extent to which the members of a covered group use a program or obtain a particular service, or category of procedures, over a given period of time. Usually expressed as the number of services used per year or per numbers of persons eligible for the services.
utilization management	Process of integrating review and case management of services in a cooperative effort with other parties, including patients, employers, providers, and payers.
VA	Veterans Administration.
VFC	Vaccines for Children program.
VIP	Validation Improvement Plan.
VRS	Voice Response System, primarily seen as AVR, automated voice response system.
WAN	Wide area network.
waiver	Waiver allows members to move from the traditional Medicaid environment to a less restrictive environment. Some of the statutory entitlements are waved for the member.
WIC	Women, Infants, and Children program. A federal program administered by the Indiana Department of Health that provides nutritional supplements to low-income pregnant or breast-feeding women, and to infants and children younger than five years old.
workmen's compensation	A type of third-party liability for medical services rendered as the result of an on-the-job accident or injury to an individual for which his employer's insurance company may be obligated under the Workman's Compensation Act.
Y2K	Year 2000. Commonly used in computer system compliance issues.

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